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Publications

STANDING COMMITTEE ON SOCIAL DEVELOPMENT
HEALTH PROTECTION AND PROMOTION AMENDMENT ACT
MONDAY, FEBRUARY 16, 1987



STANDING COMMITTEE ON SOCIAL DEVELOPMENT

CHAIRMAN: Johnston, R. F. (Scarborough West NDP)

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Cordiano, J. (Downsview L)

Cousens, W. D. (York Centre PC)

Hart, C. E. (York East L)

Jackson, C. (Burlington South PC)

Reycraft, D. R. (Middlesex L)

Substitution:

Pierce, F. J. (Rainy River PC) for Mr. Cousens

Clerk: Carrozza, F.

Witnesses:

From the Stop Vaccine Damage Association for Vaccine Damaged Children:

Tetu, E.

Rothwell, D.

Bannister, H.

Howes, N.

Kortikaas, C.

Moskalyk, S.

Nusbaum, D.

From the Ontario Medical Association:

Krauser, J., Associate Director, Health Services

Hilliard, Dr. N. B., Chairman, Public Health Committee

Chevas, Dr. R., Member, Public Health Committee

Gold, Dr. R.



LEGISLATIVE ASSEMBLY OF ONTARIO
STANDING COMMITTEE ON SOCIAL DEVELOPMENT
Monday, February 16, 1987

The committee met at 14:10 p.m. in Room 2.

The Chairman: I call the meeting to order.

We have our technical problems out of the way, I hope, and we'll be able to proceed smoothly along.

Today we are dealing with Bill 52, a Private Member's Bill standing in the name of Mr. Pierce that was referred to the committee. And we will be hearing parents and the OMA this afternoon - it's more dealing with a clause-by-clause discussion of the bill.

Before we call some of our guests before us today to chat with us, I want to just run through the rest of the schedule for this week, which you have all had circulated to you, just to confirm with you that everything is in order.

We will be meeting Monday afternoon, Tuesday, Wednesday and Thursday where the committee will deal with both this Bill 52 and, following that, 176 and 177, the nursing home amendments.

We have, at the moment, as you will see, witnesses confirmed up until the end of Tuesday afternoon and, as you may recall, we were going to have this by invitation only on those bills and, if there was information arriving to us in written brief form, for which the deadline was February 27th, we might call people back for that, but, to this point, we are only going to be calling for the people that you see on the list. If there are people who you think should be coming forward as witnesses who were not invited to this point, I would appreciate you telling me or the clerk at your earliest opportunity. You can see we do have a few gaps. One possible one, which I will confirm with you, later on if there are any changes.

Any questions on the agenda?

I'm seeing none. Then, let us proceed with Bill 52.

I think the easiest thing for us to do, because we have already had a brief discussion of this matter, at this point, would we rather have any opening remarks from Mr. Pierce or have the witnesses come forward and deal with that?

Did you want to make some opening remarks, Mr. Pierce?

Mr. Pierce: Mr. Chairman, two opening remarks, very

short, and that is to display my appreciation to the committee, first of all, for being prepared to accept Bill 52 at this stage and offering the public to participate in the bill and I think, rather than go into any long-winded discussion about the bill at this time, it would be to our advantage to listen to the presentations and have questions that are presented.

Thank you, Mr. Chairman, and members of the committee.

The Chairman: Mr. Callahan.

Mr. Callahan: This bill initially came before the Select Committee on Health and we felt it was more appropriate to send it to the Social Development Committee as it would be dealt with much more expeditiously and, for that reason, it was sent here with the unanimous consent of all the members of the Select Committee.

Mr. Pierce: That's very much appreciated and, certainly, again, I say much appreciated that the Resources Committee was able to put it into their tight agenda as well. Thank you.

I think, as well, it indicates the interest that's shown in the importance of the bill and it bodes well for those that have spent a lot of time and effort in making sure that the bill has come forward.

We may proceed.

The Chairman: Well, let's call forward, then, the three representatives, Mr. Tetu, Ms. Bannister and Ms. Rothwell, and ask you to come and take -- there are only two seats there. You may have a seat and explain just how things happened and then we can take it from there.

Clearly, we don't have the three people in front of me that I thought I had, unless one of you has recently gone through a sex change.

Mr. Bannister: Excuse me. My wife got stagefright; so I am taking over.

The Chairman: Are you Mr. Rothwell?

Mr. Bannister: I am Mr. Bannister.

The Chairman: Mr. Bannister, okay.

The way things work, there are mikes in front of you that you can see. There will only be two, I presume; so if you aren't directly in front of one, try to speak relatively directly to the mike and that will be picked up on the Hansard recording. You shouldn't have to elevate your voice

and it will be fine.

Why don't you introduce yourselves and then take us through your presentation any way you would like to.

Mr. Tetu, I'm glad you were able to come and I'm glad you were able to assist with the travel arrangements, with Mr. Pierce's recommendation.

Miss Rothwell.

Ms. Rothwell: Mrs.

Would you like to introduce yourself, Howard, and say a little bit about Jeffrey?

Mr. Bannister: Sure.

As I have already mentioned, my name is Howard Bannister and I am from Markham, Ontario. My wife and I have a child that was damaged from the pertussis vaccine at the age of four months and the effect of this was devastating. It happened the same day that the shot was received and the convulsions and the brain damage sustained left him retarded so severely that he's blind, deaf, bedridden and needs constant care on a daily basis.

Now, this is our first child. We have three other children and none of them has been vaccinated or inoculated and they are not in the program at all and will not be, on the advice of our doctors.

Mr. Tetu: My name is Ed Tetu. My wife Lois and I are here from Stratton. It's a small farming community near Fort Frances. We are the parents of a ten-year-old daughter, Melanie, who has severe brain damage that we feel is a direct result of the vaccine; so, first of all, I would like to thank Mr. Johnson, the Chairman, and members, for showing the concern that you have in this matter in acting on Bill 52 as quickly as you have. Before it was moved to this committee, we had figured we had been just forgotten.

I would also like it to be known that both Lois and I are very grateful to Mr. Pierce for the concern he has shown in his efforts in trying to make this a safer province for all children. A year and a half ago, Mr. Pierce took time out and spent four hours in our home reviewing some of the evidence of Melanie's problems related to the vaccines.

As all the members are aware, we live in a very sparsely populated area. We know of several children within a year of Melanie's birthday who have been diagnosed as having cerebral palsy. From our hospital alone, where approximately 50 children a year are born, we know of three children with so-called cerebral palsy. After seeing some

of their medical records and talking to the parents, we believe these children, too, have been vaccine-damaged.

Being members of the Association for Vaccine Damaged Children, we are well aware that this problem is not confined to our area alone but, indeed, to the whole province and further.

I do not intend to go into a whole lot of detail right now. We came here to share whatever information we could with you and to answer whatever questions you might have. I would hope that during the discussion period and later, if necessary, not only us but the other parents present might be able to share some of their experiences so that you might be better able to see some of the changes required for the very serious complications as a result of vaccines.

Mrs. Rothwell has prepared, on behalf of the Association, a more detailed presentation, and I didn't feel that it was necessary for us to go into a whole lot of detail and duplicate everything.

The Chairman: Mrs. Rothwell.

Ms. Rothwell: Good afternoon. I am Donna Rothwell, the mother of an eight-year-old boy, Patrick. Patrick was left blind, severely retarded and with a multi-seizure disorder from his severe reaction to the DPT-polio vaccine. I will be making a presentation to you today on behalf of the Association for Vaccine Damaged Children.

First of all, I wish, on behalf of the Association for Vaccine Damaged Children, to thank all the members of the Social Development Committee for giving Bill 52 their prompt attention. I also wish to thank Mr. Jack Pierce of Rainy River Riding for introducing Bill 52 originally. This bill addresses a serious deficiency in our health care system; that of mandatory reporting of severe adverse reactions to childhood immunizations.

For the parents here today, it comes too late, too late for their children. Yet, as an organization, we strive to do our utmost to see that as few children as possible are sacrificed in the future.

Our proposed amendments to Bill 52 are as follows:

1. 37(a)(1), in this section --

Mr. Pierce: Mr. Chairman, I have circulated copies of the amendments that are suggested by the Association for Vaccine Damaged Children, and they will be properly introduced tomorrow when we are doing clause-by-clause, but, for the benefit of all the members, the package of the proposed amendments is included at your desk, if you would

like to follow along with the presentation and the Amendments as they are proposed.

Sorry, Donna.

Ms. Rothwell: No. 1. 37(a)(1), in this section, a severe reaction includes, but is not limited to:

- (a) Persistent crying or screaming.
- (b) Anaphylaxis or anaphylactic shock, collapse.
- (c) Convulsions and/or seizures or seizure activity, which include grand mal, petit mal, absence, myoclonic, tonic-clonic and focal motor seizures - seizure activity which includes, but is not limited to, jerking movements in limbs, startle response, eye crossing, twitching, staring spells, stiffening of body and/or limbs, arching of back, head dropping to chest or suddenly dropping to floor.
- (d) Fever of more than 103 degrees Fahrenheit with the use of fever-control medication. Any fever with fever-control medication.
- (e) Any acute complication or sequela (including death) of an illness, disability, injury or condition which followed any childhood vaccination or a severe reaction to any childhood vaccination.
- (f)(1) Encephalopathy (or encephalitis). Any significant acquired abnormality of, injury to, or impairment of, brain function, which includes but is not limited, to focal and diffuse neurological signs, increased intracranial pressure or changes in level of consciousness, with or without convulsions/seizures. Signs and symptoms of encephalopathy (or encephalitis) include, but are not limited to, high-pitched and unusual screaming, persistent inconsolable crying and bulging fontanel.
- (f)(2) An encephalopathy associated with infection, toxins, trauma or metabolic disturbances which occurs in an infant or young child who was healthy prior to immunization.
- (g)(1) Death - Any death of an infant or young child following inoculation of any childhood vaccine where the infant displayed a severe reaction to the vaccine.
- (g)(2) Any death of an infant or young child where any adverse reaction was not detected but, upon autopsy, is found to have abnormal conditions present in the body organs, including inflammation, congestion, swelling or hemorrhage of the brain, lungs, liver, larynx and trachea, kidney, spleen or thymus will be subject to a complete medical and pathological investigation to determine an association with the death and immunization of any childhood

vaccine. If such an association is found, it is to be reported as a severe reaction to vaccine.

(h) Loss of muscle control (temporary or permanent).

(i) Allergic hypersensitive reaction, (hives, swelling of the mouth, wheezing, asthma).

(j) Severe local reaction (large, red, hot and hard lump at the injection site).

(k) Sudden change in behaviour, sleep patterns or personality.

(l) Onset of illness, including, but not limited to:

1. Rash or other type of skin eruptions.
2. Breathing difficulties (apnea or other)
3. Persistent coughing.
4. Persistent nasal discharge.
5. Severe diarrhea.
6. Otitus media.
7. Projectile vomiting.
8. Failure to thrive (weight loss, general poor health).
9. Frequent infections.

(m) Onset of any of the diseases for which immunization has been given.

(n) Onset of arthritis.

(o) Hypoglycemia.

37(a)(2). A physician or a person registered under part IV or part VI of the Health Disciplines Act to practice nursing or pharmacy who, while providing professional services to a child who has been immunized against any childhood disease, forms the opinion that the child is suffering or has suffered from a severe reaction to such childhood immunization shall, as soon as possible after forming the opinion, report thereon to the parents or guardians of the child, the Medical Officer of the Health Unit in which the professional services are provided and to Health and Welfare Canada, Bureau of Epidemiology regarding the severe adverse reaction. Further immunizations will not be given to the child until due consideration is given to the matter by all parties.

2. Section 38(1) of the said Act is amended by striking out "or a virulent disease" in the fifth line and inserting in lieu thereof "a virulent disease or a severe reaction to any and all childhood immunizations".

3. Section 99(2) of the said Act is amended by striking out "or" in the second line and by inserting after

"disease" in the third line "or a severe reaction to any and all childhood immunizations".

We have no changes for No. 4 or for No. 5.

As parents of children left severely and permanently damaged by severe vaccine reactions, we wish to see some radical changes made in the current vaccination program. We want other parents and their children to have the information vital to them in determining whether or not they wish to have their children immunized with certain vaccines, information we were never given, the choice that we were never given.

Every parent who is considering vaccinating their child should be given information, first, about the diseases that immunizations protect against and the frequency of the diseases in this country; secondly, they should be made aware of all the contra-indications to immunizations and asked pertinent and relevant questions about their family medical history, where other contra-indications may be found; third, they must be informed of the possibility of a severe adverse reaction occurring in spite of the precautions already taken, and they should be given explicit details of the signs and symptoms of a severe adverse reaction to vaccine.

This should have been done long ago as a moral obligation by the administering nurse or physician.

Our organization is also extremely concerned about the continued use of the whole-cell pertussis vaccine on young babies. We have long stated that it would be a progressive step to delay a child's first immunization with it until the age of six months or at least delay the shot in the case of premature and low birth weight babies.

We realize that the risk of whooping cough is the greatest in young infants but do not think the early administration of the vaccine has done much to curtail the disease in this very young age group. It takes a series of three shots to adequately provide any protection from the disease whooping cough. Why risk vaccine damage in children so young when those who are going to get whooping cough will get it in spite of the first or second inoculation.

There has long been a suspicion that Sudden Infant Death Syndrome may be, in some instances, linked to a severe reaction to vaccine. Sudden Infant Death occurs most frequently in babies under the age of six months. By delaying the inoculations until six months of age, it would alleviate some of these concerns and possibly save some of these children.

The Association for Vaccine Damaged Children would

also like to see this province strive to provide the safest vaccines available to our children even if that means purchasing them from other countries temporarily until our manufacturers develop the technology needed to ensure that the vaccines they are producing are up to the safest possible standards.

We are aware as well of recommendations to satisfy the urgent need for compensation for vaccine-damaged children and their families. We are here before you as an association involved directly with these children and have to tell you that none of the loudest voices speaking out in favour of compensation for our children has ever contacted us for our input into such an important issue.

There has been a general denial and lack of interest by the medical establishment into the plight of the children and their families. They are afraid that, before any compensation program can be introduced, a change in attitude must occur. Medical professionals will have to first be willing to identify and diagnose children damaged by vaccines. They have, thus far, done so very sporadically and inconclusively. They have offered very little information to these families and have not been supportive. Some of our families have even been denied access to their child's medical records when they suspect vaccine damage. Thus the need for legislation as contained in Bill 52.

Bill 52 was drafted, not as a vaccine safety bill or compensation bill, but simply a bill to initiate a mandatory reporting system of severe adverse vaccine reactions and to increase awareness and knowledge of the frequency of these tragedies. We are told that permanent damage caused by vaccines is very rare, but we fear that that is not the case. We must have a mandatory reporting system of adverse vaccine reactions if we are ever going to know the truth about vaccine damage and just how rarely or how frequently it occurs.

As this issue has been neglected for far too long now, we, The Association for Vaccine Damaged Children, wish to see Bill 52 passed into law as soon as possible. To try to delve into such matters as vaccine safety, contra-indications to vaccination and compensation for victims of vaccine damage within Bill 52 would only serve to delay this urgent legislation further.

For the sake of all our children and their wellbeing, we urge you to expedite the passage of Bill 52 into Ontario law. Help us to stop vaccine damage.

Thank you.

The Chairman: Is that the end of your presentation collectively at this point?

Brief questions or comments from the members?

Mr. Pierce.

Mr. Pierce: Thank you, Mr. Chairman, and to the members making presentations, thank you for your presentation as well.

Let me ask you - I have been criticized for the bill not being broad enough and not taking in enough of an area as it reflects on different vaccinations, not only the DPTP vaccination but for other diseases as well.

Do you have any comment on that?

Ms. Rothwell: Well, with our amendments we want to cover all childhood immunizations and we wish the bill to include all childhood immunizations.

Mr. Pierce: If this bill had, in fact, been under legislation when your children were first being inoculated, it would have assisted you in determining what was going on?

Ms. Rothwell: I believe so, because the medical profession then would have been more aware of adverse reactions. When my child was damaged, the doctor who gave him the inoculation told me he had never heard of such a thing; so Bill 52 has certainly made him aware that adverse reactions do occur and they can be severe.

Mr. Pierce: Mr. Bannister, did you say in your presentation how many inoculations your child had before you recognized the following?

Mr. Bannister: No, I didn't say that. It was the second one.

Mr. Pierce: Were there any recognizable signs after the first vaccination?

Mr. Bannister: No, it was the second vaccination.

Mr. Pierce: Everything was normal after the first vaccination; so a reporting mechanism wouldn't have done you any good then?

Mr. Bannister: Well, I wouldn't say it wouldn't have done any good. Everybody's metabolism and makeup is different. Who in the medical profession really knows how it's going react. I think you should have that choice, though, because your makeup -- everyone's is different and the concern is, having this shot administered at such a young age of four months, I think is out of the ordinary and at a very crucial stage of the child's age.

Mr. Pierce: But this bill doesn't rectify that problem in respect to what age groups are going to be inoculated? It only goes to say that, after the inoculation process is started, there be a mechanism for reporting adverse reactions.

Mr. Bannister: Yes.

Mr. Pierce: So that there is still a problem beyond the bill itself. There is still another problem out there, and that is, at what age group inoculations are started.

Now, I believe, Mrs. Rothwell, in the proposed amendments, there are some changes suggested in the approach of the inoculation as well.

Ms. Rothwell: I'm sorry. I don't understand what you mean; the approach of the inoculation?

Mr. Pierce: Let me back up.

I'm sorry, it was in your presentation in respect to the ages that are affected. Okay.

Mr. Tetu, do you think that had the bill been, in fact, part of the legislation and part of the Health Protection Act, it would have had an effect on your child?

Mr. Tetu: I think, definitely. What Mrs. Rothwell just said, it would make the doctors more aware, but Melanie screamed for three days before we took her to the doctor, and it was called teething. If at that time, it would have been reported, we really feel she wouldn't have the brain damage she has today.

She had a brain scan done when she was three years old describing brain damage to the left hemisphere, and cerebral palsy is not supposed to be progressive. We also had a CT-scan done two years ago, I believe, or three years ago, in Toronto here, and there is more damage now than there was when she was three years old. In the original brain scan, there was no damage in the right hemisphere at all and, now, there is.

Not only that, after the brain scan, we saw, as time went on over the years, while she was getting these shots, that she was deteriorating. She not only had her full round of shots but there were even extra shots pumped into her, more than a normal, healthy child would get. Her last shot in 1982 was her second preschool booster, which shouldn't have even been given to start with, but they lost the records for the one in '81, apparently.

She had a seizure a week to the day before she was given that needle; so, personally, I would like to see this

bill go a lot further for parent warning and that sort of thing, but I have no intention of trying to change the context of the bill because this is a good start. It's really a good start.

Mr. Pierce: Well, Mr. Tetu, how many shots did your daughter actually receive?

Mr. Tetu: She had her first three. Then, at a year old, she should have been given an MMR. The health nurse gave the MMR and the 18-month booster in reverse and, according to the Ministry of Health, there was supposed to be a year's space between the third DPT shot and the 18-month booster. They were given too close together, for some reason.

Then, at four to five years, they're supposed to be given a preschool booster, and she was given one in '81 and, like I said, when we questioned the health unit in Thunder Bay, they told us the reason that she was given the second one in '82 was, apparently, the records were lost for the one in '81; so they went ahead and gave her the one in '82. A week after the seizure, we found the records for the one in '81.

One of the other children back home, I might add, also had two preschool boosters plus; she had a reaction. It's right in her records - adverse reaction after her first needle - and they delayed her shots until she was 8 months old, after the first one, and they started the round all over again. They gave her her first three after entering into the records - adverse, restart. After her measles shot, it's in the records - hives, neck and chest; adverse.

The parents were never ever told once that she was having an adverse reaction and she, too, had two preschool boosters plus the extra one at the start. She had two extras.

Mr. Pierce: And, yet, it shows in the medical records that she was having the reaction at the admission of the doctor but strictly for his own records.

Mr. Tetu: That's right.

Mr. Pierce: The bill, of course, is designed to mandate that doctors are required to report. The present Health Protection Act, of course, only suggests that doctors should report, and that's all it says in the present Act; that if a doctor recognizes a reaction, he should report it, but there is nothing that says that he has to report it or that any record has to be kept of it, and this is, of course, the intent of the bill; that there is a record; that it has to be reported under the Act. So that there is an onus on the doctor then to report it and, of course, that

action is under the jurisdiction of the Ontario Medical Association, in that part.

Mr. Chairman, I think I will open up further questions and, then, I'd like to come back.

The Chairman: Mr. Callahan.

Mr. Callahan: I just wanted to enquire...

I noticed that, in your proposed amendments, (a) through (o), are listed a wide number of observable symptoms. I gather -- are they all related to the pertussis reaction?

Ms. Rothwell: No, some of them, a lot of them, are related to the pertussis vaccine but they are related to the other vaccines as well.

Mr. Callahan: What other vaccines? Tetanus and...?

Ms. Rothwell: Well, the measles vaccine, the rubella vaccine, tetanus and diphtheria.

Mr. Callahan: So I gather, then, that that's the limit to which these observable matters are related? They are not related to other types of shots that --

Mr. Tetu: Well, the measles, yes, it's quite well known to cause seizures. In fact, in our case, Melanie went into a grand mal seizure that lasted two and a half hours. We just about lost her. That was her first seizure. It was after her measles shot.

Mr. Callahan: The reason I ask is that I noticed that you are also asking for, at section 38, to state a virulent disease or a severe reaction to any and all childhood immunizations. You are asking that Mr. Pierce's bill be enlarged to enhance a broader area of vaccines and all of that?

Ms. Rothwell: Yes.

Mr. Tetu: Another thing that maybe I could state is that, in Mr. Pierce's bill, it refers to this shot that we are talking about as DPT. It is not DPT; it is DPTP, and if anybody here is aware or if you would like to check, Diquad is well-known and it's used in Ontario. It was discontinued in the United States because, when they added the fourth component to it, it became far too reactive. When I questioned Dr. Friesen, our public health doctor at home, on that, his reply to me was, you know, I was really shocked when I first moved to Ontario and found that we were still getting away with it. If he is our public health doctor, what's he doing about it?

Mr. Bannister: I will add something to that. I am going to back to 1962, and the shot that was being administered then was DPT and Diquad, and that's going back to 1962. That's 25 years ago.

Mr. Callahan: I just wanted to ask you, as well, Mr. Bannister - You have indicated that, because of the tragedy with your first child, your other two children did not receive the vaccination. Was there anything that was able to be determined or were there any tests that were able to be determined that the other two children would be at risk as well?

Mr. Bannister: Well, my second child was a boy as well and, of course, being a hockey fan myself and my boy involved in hockey, he had a severe cut and, when I had him stitched up and so forth, they wanted to give him a shot for tetanus. At that moment, we discussed our problems with our first child - I was living in Brockville at the time and Jeffrey was born in Ottawa and our doctor was in Ottawa. I contacted him relative to him receiving the tetanus shot and he advised me, no, don't have it done.

Mr. Callahan: Well, do you know that it was the pertussis portion of the vaccine that injured your child?

Mr. Bannister: Yes, I have a record of that.

Mr. Callahan: I gather the tetanus -- there is no indication that the tetanus was...

Mr. Bannister: No, but he preferred that the shot not be given, period. He said, I understand the risk but, he said, don't have it done.

Mr. Callahan: I guess that's a very real possibility, that if pertussis is the perceived bad... I don't know if you'd like to use the word "bad apple", because it obviously helps a lot of people very significantly, but if it's the particular item that has caused a tragedy in your family and others, it seems as though, in your case anyway, that the fear of pertussis is quite understandable and that your doctor has also a great concern about the additional vaccination of the tetanus and the... Did the child have the polio vaccine?

Mr. Bannister: My first child?

Mr. Callahan: No, the other two.

Mr. Bannister: No, none. They haven't had any shots.

Mr. Callahan: So I can conclude from that, at least in your case and perhaps in many other cases, because of the

concern about the tragedy and then the concern about the pertussis, other children, only as a matter of, perhaps, an overabundance of caution, are being denied the access to the tetanus and the polio vaccine?

Ms. Rothwell: May I say something about that?

Mr. Callahan: Yes.

Ms. Rothwell: My son Patrick, we were told that it was the pertussis component of the DPT polio vaccine that caused his damage. Now my child is severely damaged and how do we, as parents, know, or how does the medical profession know, that it was just the pertussis component in that quadruple vaccine that affected him? And what would ever make me want to take the chance that there was some other type of reaction involved?

Mr. Callahan: I am not suggesting that. All I am saying, and I guess what I am trying to clear up is the question of, if you did limit it just to the pertussis component, as Mr. Pierce has suggested in his bill, you might create that fear amongst other people in terms of the other components.

Ms. Rothwell: Yes.

Mr. Callahan: Thank you very much.

The Chairman: Mr. Reycraft.

Mr. Reycraft: Thank you, Mr. Chairman. A couple of questions, two or three, and none of them are related.

When we talk about expanding the bill to cover all childhood immunizations, what vaccines are going to be included in that, other than that for measles that we have talked about?

Ms. Rothwell: Well, we would like to see it cover all current childhood vaccines and any future childhood vaccines.

Mr. Reycraft: It's been ten years since my wife and I went through the vaccination process. Can you refresh my memory on which ones are included?

Ms. Rothwell: Yes. The current vaccines are the DPT polio vaccine and the MMR which is measles, mumps and rubella vaccine, and they are the currently recommended and mandatory vaccines for children.

Mr. Reycraft: There are no others?

Ms. Rothwell: There is some talk about the VID

vaccine.

Mr. Tetu: The influenza vaccine for daycare. The Ministry of Health has really been pushing that for the last year, or whatever. I'm not too up on that.

Mr. Pierce: Move up closer to the mike because we're having a hard time hearing you.

Mr. Tetu: Oh, I'm sorry. I was just saying that the latest vaccine is what we call the VID vaccine for some type of influenza, and I haven't studied that very much.

The Chairman: Perhaps you can explain that.

Mr. Pierce: A supplement to that.

What is trying to be impressed here is that any adverse reaction to any vaccination that's given to children should be reported, but, you know, I can appreciate you wanting to know what all the vaccinations are and what all the vaccines are. But it's any adverse reaction, so that it's really immaterial which vaccination it is as long as, if there is an adverse reaction to it, it should be reported, or has to be reported.

Ms. Hart: Mr. Pierce, isn't this really any reaction we are talking about? Aren't you limiting it when you say "adverse"? We want to know any kind of reaction?

Mr. Pierce: The definition of "adverse" is really the key to the thing - what is an adverse reaction.

Ms. Hart: Well, that's why I'm saying that. Do you want to limit yourself that way? Why don't you just say "any reaction".

Mr. Tetu: As broad as possible. What we are trying to say, as parents and as a group, is that we are not here to defend or condemn the vaccines, but some of the health people in this province recite statistics, and most of them are from a study that's been done in Great Britain, a Master Encephalopathy Study.

We have been unable to ever find out whether there has been a study done in Canada or not. There might have been. It has never come to our attention, whether there has or not, although we have enquired.

By this mandatory reporting and recording, the vaccines are going to speak for themselves and, if there is a real problem with one, well, we don't have to sacrifice all these children. If there is a "hot lot", supposedly, nothing can happen; it can be withdrawn before it does have widespread implications. It's just going to make things

safer for all of the children in this province. It's something that should have been done years and years ago.

Mr. Reyecraft: Mrs. Rothwell, something you said in your presentation suggested to me that there were safer vaccines. There are vaccines that are safer than the ones being used here in Ontario available in other jurisdictions.

Can you expand on that for me?

Ms. Rothwell: Yes.

There was a split-cell pertussis vaccine developed by the Lilly company in the United States in the 1960s. That vaccine was never produced and was never marketed. It was tested and found to be less reactive than the whole-cell vaccine. Why it was never manufactured, I don't know. Currently, there is an a-cellular vaccine in use in Japan which is a lot less reactive than the whole-cell pertussis vaccine, but again it's used in Japan. It's not being used here, and that vaccine has been in existence since 1981.

Mr. Reyecraft: I'm sorry. I didn't hear what kind of vaccine.

Ms. Rothwell: A-cellular.

The Chairman: What does that mean?

Ms. Rothwell: It means that they have taken away a lot of the cell. The whole cell vaccine contains the toxins that cause the adverse reaction. With the split-cell, they eliminated some and, with the a-cellular one, they have eliminated as many as they can.

Mr. Reyecraft: Thank you. That's fine.

The Chairman: Mr. Jackson.

Mr. Jackson: Thank you, Mr. Chairman. My question has to do with the statistics.

My understanding is some jurisdictions in Canada have been monitoring or measuring or addressing this issue perhaps more carefully than other provinces. Could you enlighten the Committee with respect to some of the differences between the provinces and, more particularly, your feelings about the statistic I read in your larger brief that 1 in 60,000 children are damaged or dying as a result of it. There is some belief that that statistic may not be as low as that in ratio.

Ms. Rothwell: That statistic is based on 310,000 shots. Our children receive an average of three to five shots; so, if you divide that by three or five, there is

between 60 in 100,000 children. That statistic, I believe, comes from the National Encephalopathy Study in Great Britain, which was done better than ten years ago.

There, children are not immunizeed. They do not receive their first immunization until they are six months old, and it is our information that their vaccine was less toxic than the one used here in Canada. So, we believe that the numbers of damaged children in Canada would be greater than what is quoted by that figure, and we have recently learned that the western provinces, apparently, are the provinces who are mainly responsible for the list of adverse reactions that they have in Ottawa at the National Advisory Committee on Immunization; that they are really quite diligent in reporting adverse vaccine reaction as compared to the larger provinces, the more populated provinces, Ontario and Quebec, and the eastern provinces.

Mr. Jackson: Well, I remember reading somewhere in the material that, in fact, the situation in Alberta, they are diagnosing more children with adverse reactions --

Ms. Rothwell: Yes.

Mr. Jackson: -- as a percentage of their child population.

Ms. Rothwell: Yes.

Mr. Jackson: And I understand, as well, from some articles in the paper that there are several states in the U.S. This is not a universal thing; it varies by state, but there are a few states. I think Georgia was one of them, more recently.

Ms. Rothwell: Yes.

Mr. Jackson: So, fix for the Committee, if you would, where Ontario is in terms of its understanding and its sensitivity to this issue.

Ms. Rothwell: I would say that Ontario is quite a bit behind yet. We have heard that doctors are now explaining the risks involved with some of the vaccines, but we also hear that doctors are telling parents still that children have to have it and there are no such things as adverse reactions.

Mr. Jackson: Well, if The Chairman will allow me to bring up Amy Elizabeth, my 11 months and 7 days old daughter, it's been a month since I mentioned her in the Legislature; now, give me a break.

I can identify with that, having just gone through that experience several months ago and still yet to complete

the full process. It left me with some lasting impressions about the situation that I find myself in as a parent with the kinds of responses I get based on the question, and I thought that I was a rather informed parent, given the material that Mr. Pierce had given to me when my daughter was born.

My final question, and I would perhaps like to ask all three deputants, if you could, to please share with us, albeit somewhat painful -- if you would share with us the sequence of your individual child's first reaction.

For some of you, I understand, in some cases, it was not with the first shot and, for others, it was with the first shot - and that is an area which might illustrate for me, again, and the Committee, perhaps how the reactions can vary so significantly.

If you could just do that again for me because I thought some of you did and others didn't.

Ms. Rothwell: Well, we will start with Patrick. He had his first immunization at the age of three months. His initial reaction, when we brought him home from the doctor's office, was he would jump. We would cuddle him and get him off to sleep and he would jump awake as though he had either heard something or something frightened him, and he was scratching at my husband's shirt, which we noticed because we had never seen him do that before, and I commented that he must like the material or something. Each time we would settle him down and, later that evening, he started screaming and crying and it was very difficult to settle him. This went on for several hours, and then he seemed to settle down and back to normal by the next day.

His second inoculation, we are not too clear on what happened at that point, but, after his third one, the screaming syndrome came back again and it just continued and continued. We asked about his reaction - could he have been sick? Could that have caused it?. No, we were told, he was probably teething. When he was three months old, they said it was probably colic and never was it ever indicated to us at that time that it was a reaction to the vaccine or that we should discontinue giving our child that vaccine.

Mr. Bannister: With our child, I recall it happened at four months. He was taken in the afternoon for his second shot and was brought home and put to bed that evening after being fed. During the night, he was crying and making loud sounds and my wife and I kept running in, back and forth, to his bedside to see what was wrong with him. That happened all through the night. There was high-pitched screaming from him.

The following morning, I proceeded to go to work and,

after I had arrived there about 8:30 in the morning, my wife called me - she was in the process of feeding Jeffrey and he went into a seizure; like, just stiffened his hands and feet and dropped his head and his eyes rolled back in his head. Of course, she followed that up by calling me and we had him admitted to the hospital immediately. That was in Ottawa, the Civic Hospital.

He was kept in there for several days and diagnosed as -- they weren't sure what was the problem. From there on in, we were sent to the Sick Children's Hospital in Toronto where it was diagnosed that he had received severe brain damage on all sides of the brain.

Mr. Jackson: This was the second inoculation?

Mr. Bannister: The second.

Mr. Jackson: How far apart was that?

Mr. Bannister: Probably it would be - I'm not sure on the months - one month.

As a result of the stay at Sick Children's, Dr. Harry Bing, who was Chief of Pediatrics here who performed this test, said he had encephalitis. The cause of it was never made known to us by our family doctor or by Sick Children's in Toronto.

I furthered the matter by wanting to take him to the Montreal Neurological Institute for further testing, and I was advised by Dr. Bing that there was brain damage in one cell; that's unfortunate, but there is no way that it can be restored. That's the end of it; so there is very little hope for your son. That's about the size of it.

From there on, he just deteriorated and lost his motor development. He became blind and couldn't walk, and deaf. He is 24 years of age and he's completely retarded. We have him in a home at the present time.

Ms. Rothwell: Would it be possible for me to excuse myself and let another parent come forward that you may ask questions of that may have a little different story to tell than me?

The Chairman: Certainly.

Mr. Tetu: In our case, I would like to reemphasize that we had no idea - Melanie was eight years old before we had the faintest idea that it was even the vaccines that caused her problems. After her first needle in June of 1976, there was prolonged crying --

Mr. Pierce: And how old would she be in June of 1976?

Mr. Tetu: She was three months old, and that was her first needle, prolonged crying. Lois, my wife, took her back to the same doctor that gave that needle -- and a lot of the things I am saying now is not from memory; it's from records. We first became aware of it when we saw a documentary on 20/20, on television, and it was shown on THE JOURNAL that same winter. That was when we started digging into the records and piecing things together, and my biggest fear is that there are numerous children out there that their parents aren't a bit aware that they are even reacting or that they have suffered damage because of the vaccine.

She was taken back to the same doctor that give her that first needle and he had entered on her chart "first DPTP". When Lois took her back six days later after her crying for three days day and night, the same doctor pulled that chart out and he had to have seen where - to jog his memory a little bit - where he had just given her a shot six days before. He wrote down underneath that, "Teething. Prescribed atarax", which we've since learned is a sedative for allergies.

The second needle, it was the same thing, the same amount of days. She was taken back to a different doctor because that clinic was closed. Her mother and sister had to babysit Melanie the night before she was taken back so that Lois could get some sleep - she had been screaming day and night. Her sister can remember, along with Lois, that Melanie's back was just arched and she screamed all the time, even in the doctor's office, and jerking movements. The doctor, again, said it was teething and prescribed phenergan which is, again, a sedative for allergies.

There has to be something done where the parents are really informed as to the possible reactions so that they can go back to their doctor and tell him what's been taking place.

Melanie had her first tooth at nine months of age and they were calling it teething at three months. From talking to other parents, this is quite a common occurrence. All three shots were classified as teething, all the first three. Like I said, her fourth shot and her MMR were given in reverse. The dates had been mixed up.

It's just been treated like candy. This is serious business, these vaccines, and there should be some better controls out there where these people are doing it. We are putting our children in their -- their lives in these people's hands and they should start somehow being more careful in how they handle it, is what I am trying to say, I guess.

After her measles shots is when she that first

seizure. On our immunization record card that we have ourselves, there was nothing there. When we got photocopies from the health unit on their records which they keep in their office, there is a big "SD" printed underneath it. Whatever that means, I don't know. We feel that it means something like "seizure development", or whatever. They made their own little note there but nobody ever told us anything connected to it.

Ms. Howes: My name is Nancy Howes. I live in Brampton and am the mother of a two-year-old -- actually, two children - a five year old, who is normal and healthy, and a two year old, who has been left severely brain damaged as a result of her first DPT inoculation.

Patricia was born in October of 1984 and received her first inoculation on December the 6th of that same year. She went from a serenely contented child to one that -- well, within the first night of her inoculation, she moaned all night long and, the next day, her leg was very swollen and so very, very hot. She was up all that night and, of course, I was up all that night with her.

The next day she went into a coma-type of sleep and developed those types of sleeping habits over the next two to three weeks. She would be awake from six o'clock in the morning until about six o'clock in the evening, crying 95 per cent of her day, and then would go into like a coma type of sleep literally. Like, we just couldn't wake this baby up from about six to about two in the morning. We started noticing her having a startled reaction, as infants do startle to noise, and thought it was something cute that she was starting to do.

We managed to get through Christmas and, at the beginning of the new year in 1985, she was just beside herself. We used to spend hours and hours and hours rocking and rocking this baby until, January 6, 1985, I said to my husband, I have been up with her since five in the morning - she was just screaming just beside herself and she was doing this startled reaction two or three times within a minute - and we called the doctor. The doctor came to the house, took one look at her and said, you get her into Sick Kids right away; this baby is seizing on you.

I had mentioned to the doctor who administered the needle on a previous occasion what she was doing. A week prior to her hospitalization in Sick Children's, she had thrush, which is a normal fungus in the baby's mouth, and I said to him what she was doing with her arms and he said, she is probably feeling some discomfort in her mouth.

I think the biggest issue, and, with me, my absolute rage, is when you confront the doctors in the medical profession about, do you think this could be possibly an

adverse reaction to DPT? She just had her inoculations so many hours or so many days ago. The biggest issue with me is the absolute denial, and the doctors are just -- they are, you know, just fighting you. They are just saying no, definitely not.

When we rushed Patricia into Sick Kids on the 6th of January 1985, she was put in as a suspected spinal meningitis case and had an EEG done, and a spinal tap. She spent five days in isolation on the seventh floor and we were told, four days later, to take her home - Here is a big bottle of phenobarbital for your baby. Take her home. Treat her like any other member of the family. She is fine.

Three days later, she was rehospitalized. She was seizing just as bad as she was when we initially brought her in.

Patricia's life since then has been several hospitalizations, lots of anticonvulsant medication, numerous tests; you name it. We have been through it all. She was two last October. She is just now starting to sit for seconds. She is critically blind. She has a severe seizure disorder and, mentally, she is at about a 3-month-old level.

The Chairman: Mr. Callahan.

Mr. Callahan: I was going to ask a question as to whether or not, when you experienced these abnormal reactions, say, between shot one and shot two, if you mentioned it to the physician?

I gather that, in the case of Mrs. Howe, she did.

I would like to ask you, Mr. Bannister, did you mention it to the doctor as well and did you get any response?

Mr. Bannister: To be honest with you, being our first child and being sort of new -- I didn't know how to deal with doctors at that time. We were young. It was our first child.

Mr. Callahan: I guess you didn't understand that it was something of a problem?

Mr. Bannister: No. At the time, we weren't aware of what was going on. All we knew was he had a seizure in 1962. We were told it was one in a million cases that that was happening in Canada. That is what was told to us by our doctor at the time, and I just can't explain to you why we didn't go back and ask for further details at the time. It was beyond me at that stage in the game.

Mr. Callahan: I guess -- when it's your first child, none of us has had a chance to do a dry run through to see what is normal and what is abnormal.

I guess, along with the question of all vaccines and perhaps all shots being identified, in this stage of the technology, there should be some procedure available whereby the information could be inputted into a computer to be kept for, perhaps, even generations.

Ms. Howes: Of an adverse reaction?

Mr. Callahan: Yes. Because I can personally remember where one of my boys had a shot of penicillin and had an adverse reaction to it - certainly, not as tragic as those described by you people, but he had palpitations in the heart. I noticed one of the things here is irregular breathing and shock thereafter. I am always asked, is he allergic to anything, and I always say, penicillin, but it worries that, somewhere down the line, he may get a shot without remembering that and go through the same reaction.

I guess what you would like to see us do as well is provide some way of collection and collation of these adverse reaction reports in order to make them available, perhaps, for a doctor to tap into if it became necessary.

Ms. Howes: No one in the medical profession is willing to admit, yes, this does look like an adverse reaction, and that's one of the biggest issues. I know a lot of parents have confronted doctors that are very well briefed on this issue and they have been told pointblank, no, this is something that just happens to a child.

Mr. Callahan: Well, the first point was to try and get a mandatory requirement by medical people of the adverse reactions but I would think, part and parcel with that would be the collation and collection of that data in some easily retrievable way that would be available not only for your own children but, perhaps, as many of these disorders seem to be genetically carried, be available for the next generation. Thank you very much.

The Chairman: Mr. Baetz.

Mr. Baetz: I have a question that maybe Donna Rothwell could answer best, or perhaps any of you.

You are a relatively young organization, organized in 1966, January. How many members do you have at the present time?

Ms. Howe: 1986.

Mr. Baetz: 1986, sorry.

Ms. Howe: Just under 100 families.

Mr. Baetz: Have you a sense that there are many, many more families in the province that have had the experience?

Ms. Howe: We attended a conference on immunization that was held in Toronto just a couple of weeks back and, just from that, just from the publicity that we received from that, we got five or seven new members.

Mr. Baetz: So it leaves one to think that there could be a very, very much larger problem out there than is reflected in the number of your very young organization.

The other thing, Mr. Chairman, that I find personally very disconcerting in all of this, in addition, of course, to the terrible tragedies we are hearing about, is the recurring comment about the attitude of the medical profession to parents who express a concern about the possible relationship of the symptoms to the vaccination.

I would like to just ask a little further on that.

What is this? Is this simply the sort of feeling that any of us who are parents with young children, who have been through this with our medical doctors, where we are concerned parents, and the benign doctor says, well now, listen, don't worry too much; parents tend to worry. Everything will be fine. You know, these symptoms are due to the thrush that you were talking about, or something. It's nothing serious.

I mean, is that part of the reason why you are getting these answers, or is it the big bureaucracy - after all, there are thousands and thousands vaccinated and thousands and thousands have records and, oh, my God, you know, really, we don't want to make too much of this; so please don't bother us - or is there an element here, which would really worry me, of sort of a conspiracy of silence by the medical profession sort of saying well, let's not, for heaven's sake, talk too much about this because this really can get the public aroused? Where is it? Because all of you who have talked about these tragedies have pointed to this attitude on the part of the medical profession, whether it's a doctor or whether it's a public health nurse, or whatever.

I would like to get your comments on that. Your frank comments.

Ms. Howe: My frank comments? I don't really think you'd want to hear my frank comments.

The Chairman: You are not covered for libel! It's

only these guys that are covered; you are not!

Ms. Howe: We are not an anti-vaccine group.

Mr. Baetz: I realize that.

Ms. Howe: And we realize the benefits and the risks. I think, if doctors were to sit down and inform parents -- I was at that conference two weeks ago and I sat in on the pertussis issue where a Dr. Ron Gold spoke -- I sat right in the front row -- and they sat there, and it took me all my strength to keep myself seated in my seat because I -- not I. I shouldn't say I. My daughter is one of the statistics. They sat there and they very blatantly and very smugly said, yes, this does happen. These few children, very few children, are going to suffer very irreparable brain damage. That's too bad they have to pay the price and they have to suffer for the sake of the health of other children. Well, I think my feeling is -- and all the other parents of vaccine damaged children that are here will agree with me -- if doctors sat parents down and really told it like it was, this and this and this could happen to your child, would you do it? Would you have your child inoculated with pertussis if you knew what could possibly happen?

Mr. Tetu: Mr. Baetz, adding to that, you asked the reason why this is happening. Why would a doctor say to me that -- I have witnessed this and I am in the hospital, that I was right not just about Melanie but about all of the children we were talking about in the area -- he said, you are right, Ed, and I looked at him. He came up to me and he said, you're right, but I can't say it in public. Why? I don't know.

Mr. Baetz: Well, why does he feel that -- why this determination to remain rather silent? Is it so everybody doesn't get so worried about the vaccine and nobody will have to take any responsibility?

Ms. Howes: I believe so.

Mr. Tetu: When you get guys like Dr. Gold here in Toronto and he puts out publications about the risk/benefit ratio and he is sitting there in his office, I don't know what he's doing, but he sure isn't going around Ontario trying to do an honest investigation into these brain damaged children; he is reading some statistic that was done in Great Britain and he is putting this out, and there are doctors out in the country, small community doctors, they are picking this up and reading what he is telling them, and I believe that he's dangerous, that guy. I really do. He gets up on the Tom Cherrington Show there and Cherrington made a statement as if Mrs. Goldman wanted to kill 800 children, which was the statistic that Dr. Gold put out in

one of his publications, and he then admitted it was a misprint; so he said, no, she wants to kill 80.

Mrs. Goldman doesn't want to kill 80 children. She's the same as the rest of us. She wants a little bit of honesty. It's too late for our children but, damn it, we can't let it keep going on.

The Chairman: You're new at the witness table. Would you like to introduce yourself?

Ms. Kortikaas: My name is Catherine Kortikaas. I am also one half of a set of parents that has a brain damaged child as a result of this.

We have a little girl that will be four in April. Her name is Maureen. Our family lived for a long, long time in Mr. Callahan's riding and we moved.

Mr. Callahan: I hope I didn't cause that!

Ms. Kortikaas: No, nothing personal.

We moved three months before her birth to Pickering Village, and that's where we live right now. I think we are speaking and saying an awful lot about the issue of reporting but I think we have to hit on a few other phrases here like reliability, trust, responsibility; all those nice phrases that go along with enacting a set of rules.

I work in a government organization that has a policy and I have to take that policy and I have to live it, not just to the letter but to the spirit. When one has a program enacted for living for the good of the whole, one has to realize that sometimes people break the rules or that sometimes you can't live exactly or work exactly within the confines of something.

We have a child at home right now that, in all likelihood, probably would not be the way she is if, perhaps, a less negligent attitude would have been taken to some of the comments that we, as parents, made the evening after the initial inoculation. First off, parents have to be given more credit for their powers of observation. Secondly, parents have to be given the benefit of their willingness to come out to the doctor who they may, in some way, shape or form, fear for the fact that he has been 10 to 12 years to medical school to learn something. I mean, what would I know? I mean, I am just somebody off the street, right?

My husband and I both have gone to school and we are conversant in some ways with the way the medical people refer to diseases and reactions and things like that. If somebody would have sat us down and said, by the way, you

have as much to gain as you have to lose, I would seriously have given a second thought to putting my child up for this inoculation.

If the needle is made to be given and it is law to be given, then there should be something in place to have the reaction to that inoculation recorded. It's not a matter of -- it shouldn't just be a whimsical spirit as to whether or not there is a report made; it should have to happen. If the law says you give it, then there should be something that says you must report what happened. Even if the report is zip; if there is no reaction, that's the reaction - there is no reaction. If the reaction is minor, as a slight temperature or irritability, that reaction should be recorded.

Now, the reason I am particularly concerned about this element of the inoculation process, above and beyond all those other reasons that have been stated this afternoon, our first child - we have three by the way - is two years and two months older than Maureen and, at the time, he was under the care of a doctor in Peel and he reacted terribly to three sets of inoculations. Luckily, it's past, at least we think it's past. He seems to be fairly well-adjusted and normal, and when I use that term, as normal as I can possibly interpret as this child's mother, observing him and comparing him to other normal children. I mean, what am I? I am not a doctor, right? I perceive this child to be normal.

That child had a bad time after every inoculation. The child screamed for 13 hours; he had a terrible temperature, but he lived to tell about it. In his medical records, there is nowhere recorded that the child even ran a temperature. We were told it was normal; if it happens, give him Tylenol. The same thing happened with Maureen.

Maureen, as far as I am concerned, it is not just what happened, but it's also a case of negligence because there was no consultation between the parent and the medical practitioner at the time of the inoculation to even make an enquiry as to whether or not the parent was, perhaps, from an allergic-type family and possibly suffered from the list of reactions or circumstances that were described earlier this afternoon of those people that perhaps shouldn't have inoculations.

There was no discussion. It was just done. I was not even in the room at the time. The child was crying when I came back after taking my son to the bathroom. We took our child in for a well-baby-care check-up and look what's happened. We had a well child and we don't have a well child now.

Maureen is going to be four. She cannot stand up.

The thought of standing up has never occurred to her. She is severely and mentally retarded because of massive brain damage. It's sporadic all over her brain. It has been diagnosed by two doctors, one very well-known neurologist in the United States and also a well-known neurologist in Toronto, but I doubt very highly if they will come forward and support it because it's an old boy's network, as we all know, and one doctor would never say anything bad against another doctor; so whether or not we have any chance of that, I don't know.

Maureen is unable to function on her own. She cannot eat by herself. She can't even go to the bathroom by herself. She suffers from a multiple set of biological problems now as a result of the brain damage because it has affected her metabolism, and the list is endless. Come and spend 24 hours in my home and tell me what life is like.

I would like to enlighten the people that are talking about this issue around the table about life today for us and what life could possibly be like for hundreds and hundreds of families in this country who yet do not have any children or for you and your wife who have an 11 month and 7 day old child at home, who at, its next inoculation, may suffer irreparable brain damage because of either pertussis or any other concoction in that vial.

To this day, doctors are still telling their patients that you have to have this inoculation to get into school, which is malarkey. They are not sitting down and even reading the back of the package to their patients, telling them that there is a possible risk of damage. They do not weigh the bad against the good and they only toot the horns for the benefits of the vaccine but not the side effects, and there are far more real risks than there are benefits and everyone of us in this room lives with the side effects every day.

It also is extremely difficult for parents who do not have children at this point in time to understand that and, perhaps, we, as parents of those children, and you, as politicians in this fair province, could do something to benefit those people that do not yet know that they are taking their children to slaughter.

The Chairman: Mr. Reycraft.

Mr. Reycraft: Mr. Chairman, having listened to the last account, the previous ones and the reread Bill 52 and the amendments, I can't help but think that even if Bill 52 with the proposed amendments becomes law, we are still going to be as far away from the real solution to the problem as we are now because it seems to me that, in the last two situations, it was obviously the opinion of the physician that the symptoms being exhibited by those children were not

related to the vaccine.

Ms. Howe: A little after Patricia was hospitalized at Sick Children's, I called the doctor that did administer the needle, hysterical, and I told him what had happened the day previous, where she was, what they were doing, and he said, calm down, Mrs. Howes. I have to tell you something. I want you to know one thing as her mother, and I said, what is that. Patricia cannot have any more pertussis, and I said, oh, why is that? Because pertussis is known to have caused seizures. That was his comments to me.

Mr. Reycraft: But if the physician, wanting to protect himself, said, I have not formed the opinion that the symptoms are a reaction to the vaccine, then the way Bill 52 is worded, he is not required to report it.

Mr. Tetu: Mr. Reycraft, we are really begging that this bill does go forward with just a few of the small amendments covering all that sort of thing because, yes, it doesn't cover all of the things that we've stated today, but it's a start. We've made you people here that make the laws a little more aware of some of the problems. There is nothing, I don't think, stopping another bill, or whatever, that is required later. This is, at least, a beginning.

Mr. Reycraft: I guess what I am really asking for is, is there a solution that's even better than this one available to us as an option at this time? What I'm hearing is, there isn't.

The Chairman: There may not be in terms of what's in order.

I have two supplementary questions, one by Mr. Jackson and one by Mr. Callahan.

Mr. Jackson: Thank you, Mr. Chairman. On the point that Mr. Reycraft is on.

As you are now, I have struggled with this when I meet with a group of parents on this issue and it becomes abundantly clear that one of the things we could be doing, and you might do as a government member, is to enquire as to how we can get the a-cellular vaccine on our market as quickly as possible. That, we have already heard, would have an affect of limiting risk, the degree to which we would not know, but we would, as a result of the bill in its basic form, start a measuring tool for the medical profession and the Ministry of Health. Certainly, the objective would be to bring in the safer vaccine, and that's a matter which I was going to raise; the question, if we were going to receive any comment from the pharmaceutical industry, and perhaps that question more appropriately might be asked by a parliamentary assistant, in consultation with

your ministry on this bill; if there was any concern or attention given to bringing forward some comment from the ministry about the level of the safety of the current vaccine in use?

Ms. Hart: I don't know the answer, but I'll see what I can find out.

The Chairman: Tomorrow morning, before we get to the clause-by-clause, I was of the idea that we would have ministry people here to deal with questions, and I think pharmaceutical-type questions could be put at that time, Mr. Jackson.

Two comments --

Ms. Kortikaas: Mr. Chairman, I just want to make a small statement here about correcting something that was just said. The a-cellular vaccine that's been discussed, it has only been tested on two-year-olds.

The Chairman: No doubt we'll find out some of the other information on that.

Mr. Jackson: But part of the solution lies with -- certainly, there is the political will of the government to do the monitoring, but there is also the political will which says that we will develop a safer vaccine. I mean, that's so logical it's crying for attention. Whether it exists today is one point, but whether we have the political will to say that we will not tolerate a vaccine with these kinds of risks; that, as we are pursuing improvements in cancer drugs and other drugs, this is to be perceived as a means of getting a safer drug. That was merely the point I was trying to raise, and I will hope that, in the presentation from the ministry tomorrow, we will be able to fix for this Committee their understanding of the development of this vaccine and the access that the Province of Ontario has to that vaccine, because there may be some international implications with its access to that.

The Chairman: We are making a note. I am sure we will have somebody here who knows about the drug side of those.

Do you want to make a comment, Mr. Tetu?

Mr. Tetu: Mr. Chairman, I was just asking if anybody from the Ministry of Health was coming. There are a couple of questions that I would have liked to ask them if there was someone here.

The Chairman: There are some here available. The easiest thing would be to put it on the record now while we're discussing this. In fact, why don't we take Mr.

Callahan's supplementary and, before we wrap up with you, if you have outstanding questions, place them on the record now and then we will make sure they are addressed at least tomorrow morning, if not this afternoon, before the next presenters.

Mr. Callahan.

Mr. Callahan: Mr. Chairman, it becomes rather obvious, I think, as Mr. Reycraft was pointing out, that the bill itself, using the words, "after forming the opinion", really requires a number of things. It requires integrity. One would hope that integrity is there, in most if not all cases. I am sure there are cases where maybe that is not the situation.

The second one would be the question of knowledge by the doctor or the person administering the shot. In order to form that opinion, they would have to have that understanding; so, really, the way Bill 52 is brought in by Mr. Pierce, it seems to be a relatively short bill, but it would seem to me there is a great deal more that needs to be done, apart from the wording being changed, to ensure that we accomplish what you, as parents, wish to have accomplished.

In hearing some of the people who spoke, it seems to me that there was a reaction between the first shot and the second shot and, surely, if that information was made available and had to be reported by the doctor on the first occasion and it was put on some sort of a computer type of retention, one would think that the obligation would be to check that reaction before the second shot was administered because, from what I gathered, some of your children were injured permanently as a result of the series of shots.

Had they gotten the one -- perhaps it was one in your case, Mrs. Howes -- had your child only received the one shot and it had been discovered that there was a problem, you might not have had the injury that the child sustained, and I think that this bill really is not -- we all know -- and I don't say this in any light vein, but we all know the cat has to be belled. It's a question of how to bell the cat and effectively bell the cat so there are no further children who suffer from these particular injuries. So I just say, Mr. Chairman, that this bill requires a good deal more.

Perhaps in the interim, I would be interested to know if a-cellular vaccine is an interim measure while this matter is put together in terms of how to do that in the most effective way - and a quick fix is not always the best solution to a problem, and I am starting to realize this as we go through this particular bill that, as Mr. Reycraft points out, as it's presently worded, really does not fit

the bill.

Ms. Kortikaas: It's more than what we had before.

Mr. Callahan: That's not a criticism. I am just saying that it doesn't fit the bill.

Mr. Pierce: I feel that warrants comment.

Of course, the members present know the problems that are faced by opposition members presenting private member's bills, where they normally do not go beyond the table in The House, and, certainly, the families that I consulted with prior to the drafting of the bill and I both agreed that the bill had to be short; it had to be concise and it had to get the approval of The House to go beyond The House, and that's why the bill is here in this kind of content.

Certainly, in listening to the discussions taking place here today, there is nobody that would be opposed to broadening the content of the bill, and that's the message that I have been getting ever since the bill was put out and sent to committee. They have not disagreed with the bill but they believe that the bill is too short in notice and that it should go further, and that was certainly the comment by the Minister of Health, Mr. Elston, and it has been the comment of the OMA that the bill can be broadened and should be broadened and, as you've noted, there are copies of the proposed amendments that have been sent around and, certainly, I would be prepared to entertain any amendments by any other members of this committee to broaden the bill so that what we are trying to do gets recognized by the government for third reading. But I think, in fairness to Mr. Callahan, and to other members, had I brought the bill forward with all the items that were problem-related in respect to vaccinations, the bill never would have got past second reading; so that is why we are here today, Mr. Chairman.

The Chairman: We have a new deputant, who is...?

Mr. Moskalyk: My name is Steven Moskalyk and I am the parent of a five-year-old who is brain damaged, a boy named Matthew. I can go into details later on, but one thing that I hear all the time is that doctors are not -- they don't want to get into more work and report things like this, and some of it may be because they don't want it to lead to legal actions. If they are saying that; yes, I gave this shot and this baby is brain damaged because of that shot, I may be legally responsible for that. They can get sued and they're very hesitant to volunteer information at all.

Now I don't know how you can go about putting something into the bill that would relieve them of being sued or make it easier for them to report, but it's

something that has to be brought forward to say, it is your ethical responsibility to report on things that may damage children. Sure, one in a million or one in 300,000 or one in 60,000; you know, the good outweighs the bad, but that doesn't mean that we should forget about the bad or forget about the cases that didn't turn out right. There should still be an ethical kind of a thing that they should report.

One thing with our son, my wife saw a program on TV on the pertussis DPT shot before he went in to get this shot, and this was a pediatrician; this wasn't just a G.P. He was fairly young, so he probably knew about it. He, you know, in a sort of condescending manner said, well, don't worry about it. You can hear things. There are articles appearing about it but don't worry about it. It's not going to happen - and it did.

Matthew went for three shots and he had high fever, shock, stiff limbs and, all through that, well, it's either teething or a fever or something else. He wouldn't admit it's the DPT shot. And, again, I think a lot of this may be because they are very scared of legal action, especially in the States, where there are class action suits and they are suing people; doctors, the manufacturers, distributors, whoever. Anybody who has anything to do with a vaccine can get sued. In Canada, it's not like that, but it may come to that point where there's enough people getting mad enough to do something about it.

We have a daughter 20 months old, and it was really tough for us to get her inoculated. We didn't want to, but we finally said, yes. I think we waited until she was 13 months old because, apparently, that helps - the older they are, they are not as susceptible to these kinds of reactions. But we were really concerned about giving it to her and we finally said, yes, go ahead.

At that time, we knew what might happen. When the doctor gave her the shot, he said if anything happens in an hour, two hours, three hours, give me a call and we will try to do something about it. Chances are nothing is going to happen, because our family didn't seem like the kind of, you know, didn't have symptoms that we might react to it; so we went ahead with that and she is fine. She has had her three shots and she will probably have some more.

As far as Matthew, he never had another shot after those three. As far as school goes, we'll just say you know, we don't have to do it. We will get our doctor to sign releasing -- you know, saying that he doesn't have to have the shot and that's all the school board wants.

So a lot of people can say no to those shots, and I guess that's what the doctors and the medical community are worried about; that once this is more publicized and people

know that they can put their children through school without having their shots, then this will become more and more widespread and we can get epidemics of whooping cough and polio and whatever.

I mean, I agree, in general, that the good outweighs the risks in vaccination, in general, but we should do something about monitoring and keeping track of those cases where it is a tragedy, especially for the parents.

That's all I wanted to say.

The Chairman: Thank you Mr. Moskalyk.

Mr. Pierce.

Mr. Pierce: I think, Mr. Chairman, in light of the time, Mr. Tetu has some questions he would like to put on Hansard so that we can presently have some answers from the Ministry of Health tomorrow. So I would give up my questions in lieu of those questions.

The Chairman: Mr. Baetz.

Mr. Baetz: Do I understand you to say that your son has brain damage?

Mr. Moskalyk: Yes.

Mr. Baetz: That he received three shots and, that at the end of the first shot, there were troubles and severe reactions?

Mr. Moskalyk: After the first, he was feverish and screaming. It's hard for me to remember. My wife knows more about it, but I know that I took him to the hospital either after the first one or second one and gave him a cool bath to bring down his fever.

Mr. Baetz: So there were some symptoms there that obviously bothered you enough to take him to the hospital?

Mr. Moskalyk: Right, and the doctor kept insisting that he was okay; that he either had a fever or a cold or this or that, and this was right after the shot, denying that it had anything to do with it.

Mr. Baetz: And then a month later or a few months later, he got the third shot?

Mr. Moskalyk: At six months, he had the third shot.

Mr. Baetz: And that's when the real damage was done?

Mr. Moskalyk: That's when there was stiffening of his

leg and arm on his right side, and the doctor - I was in the office at that time. The doctor said, well, we should watch that. So what, you know. You can watch it until he is blue in the face. That's not going to do anything. He wouldn't volunteer information. Maybe he didn't know about it, I don't know, but I know that my wife had specifically asked him before even the first shot, because she had seen the program on TV about it, and he just sort of, like I say, pooh-poohed it and said, don't worry about it, you know. I don't think you have anything to worry about. He wouldn't admit that there was any kind of problem with it.

Mr. Baetz: Thank you.

The Chairman: I think I should remind the members that a lot of children have reactions to their first and second shots and then never show the terrible consequences that we are seeing; so just thinking that seeing a fever after the first one, it is enough to stop, it is not going to be a guide to any doctor. The percentage of kids that do have some reaction to any of the shots -- my own child had a fever. Initially I was very worried, but subsequent shots were fine, thank God.

Mr. Moskalyk: The fever may be 102, 103, but, when it's 104, 105, you get into really high fevers. You know, I knew enough that I took him down to emergency and they called the doctor there, and I figured he just was not capable. He should have realized that something was more serious than just a fever.

The Chairman: We have a new guest. Why don't we get the questions on, just to make sure we get the questions on the file and then continue.

Would you introduce yourself?

Ms. Nusbawm: Yes. My name is Dorteia Nusbawm. I don't have a vaccine damaged child. I began, along with several other people, an association called The Committee Against Compulsory Vaccination back in 1983, and it was as a result of the number of responses that we had in terms of letters and phone calls from parents with stories such as those of these parents that we encouraged the formation of the Association for Vaccine Damaged Children.

During the course since 1983, when our association formed, and 1984, when there was an amendment to The Immunization for School Pupils Act allowing for an exemption of conscience, since -- actually following that amendment, we then began to publically make statements, open up the question about the pertussis vaccine, particularly to the public because, as a result of the letters, we felt the only way to protect our children would be that parents know what the risks are because, from the letters we were getting,

physicians did not even know the side effects, the risks, what was termed a significant reaction; what was not, and, actually to date now, there has been an increasing awareness both on the physician's part as well as on the part of parents to watch for such reactions, and one would hope, with this, that the safety of all of our children would be increased.

It's frequently been spoken about this British encephalopathy study, and the thing that really concerned us, in Ontario particularly, was that, yes, you can make these quotes but, in a study, okay, very rigid standards are held, and the reason that they use the word "immunizations" instead of "children" is because, the moment that a child reacted, they were removed from the study; so, in order to follow this, they did it in terms of the word "immunizations" because so many children were taken out of the study.

Of course, in a study, you are not going to revaccinate a child who has shown a severe reaction. Therefore, we felt that, in Ontario as well as, perhaps, the western and eastern provinces, before they began doing it publicly through health clinics, which is a bit of a safeguard, we felt that there were probably many more children being damaged just simply because both the physicians and the parents did not know, one, that there seems to be a genetic component to reacting and that families will say either one or all of their children reacted - now, that may not mean that they are permanently damaged; other families will say none of their children reacted. You will get situations, such as Mrs. Kortikaas', where the one child should have already alerted that the second child probably has an intolerance to the pertussis vaccine.

Things like this have just simply not been dealt with until -- actually, it was not our intention to cause a great big fuss between the medical people and ourselves, but we really felt, for the safety of the children, this information had to come out and, then, parents could take the responsibility for saying, maybe it's your opinion that it's not a significant reaction but, in our opinion, it is a significant reaction and we don't want another injection.

I am saying that, at this point, sort of as a roundup, we feel that things are moving in a very positive direction; that both physicians, general practitioners, pediatricians, no matter where they be, are now becoming aware, and this is shown by the increase in the adverse reactions that are being reported to Health and Welfare Canada.

There was a statement in 1978. They got 118, something like that, reports of adverse reactions. To date, in 1986, or 1985 I believe, they had somewhere up in the

2,000 range of reports of adverse reactions. That's probably increasing due to the awareness of what the symptoms are of an adverse reaction, and I hope that this legislation would have some area in it which could ensure, or would give space to, the implementation of an adverse reaction reporting system to help the families, whether it be through Health and Welfare Canada or whether we have an epidemiologist who carries this responsibility here in Ontario.

That isn't really included in the bill as it stands now, and I think it's a very important part; how this program is going to be implemented should somehow be there.

That's what I have to say. Thank you.

The Chairman: Thank you very much.

Would you like to get your questions --

Mr. Tetu: Yes. I will make this as brief as possible because it is getting late.

Again, in closing, I would like to thank Mr. Johnson and all the members for the concern you have shown.

My two questions to the people at the Ministry of Health would be: It's well known, and it's stated lots by the ministry themselves, just how dangerous the whooping cough disease is. Why then, has the pertussis or whooping cough vaccine, why has it never been made compulsory? It is not one of the mandated vaccines. Have they known something all along that we, as parents, don't know?

My second question would be: It's a well-known fact that technology was available over 20 years ago to produce a safer vaccine. Why was the effort not made to have that cellular split-cell vaccine on the market over 20 years ago?

Before I go, I would like to say that we will be going back home shortly, my wife and I. We are putting our trust in you people to do the best you can with this bill and make sure it goes through with whatever amendments are possible, after hearing some of our concerns. I want it to be known that we will always make ourselves available with whatever information or help we can give to try and correct this.

Thank you very much.

The Chairman: I thank everybody who has taken the time to come forward. It's not always easy, sometimes daunting, to come and talk publicly before a committee and, more so, when it is something that is so personally hurtful to a lot of you people.

Our next presenters are from the OMA, Drs. Krauser and Gold.

Would you come forward, sirs.

The mikes are not going to be directly in front of each of you. If you are addressing us, can you try to speak clearly and close to one of the mikes.

Perhaps one of you can introduce the others.

Dr. Krauser: If I can just start off.

I hope you got the letter mailed to you on this information. The OMA hasn't looked at this bill officially, but I thought if we could bring trained physicians to meet with you, you could at least have a chance to floor some of the issues and ask some of the questions.

To my right is Dr. Hilliar, who is Chairman of our Public Health Committee. To her right is Dr. Richard Chevas, who is also a member of the Public Health Committee and a medical officer of health. Dr. Ron Gold is on my far right. Dr. Gold has worked with us over the last number of years to produce some material for physicians, educational material, and has national and international connections on this issue; so he's a very useful resource.

Mr. Pierce: Mr. Chairman, I wonder if I can suggest that one of the four sit on this side and one of the four sit on the other side and use those two mikes as well.

Dr. Krauser: I just would point out, in the letter we sent to you, because I didn't circulate it any wider, the OMA has a policy recommendation that the Ministry of Health study a vaccine compensation program and, certainly, a method of identifying cases would be part of that.

We have produced over the last couple of years two pamphlets for the public that we have given to our members to give to their patients; one on pertussis and one on HIB, which is the most recent one, and I have enclosed those in your packet. You can see that the approach taken has been to try and lay out in a clear manner the risks and benefits of using these immunization products.

Now, finally, I gave you some information on the adverse drug reaction reporting program that the OMA has conducted, and I can comment further on that, but I want you to realize that, in fact, we have had that program going for some time now and, while its purpose isn't to -- there are several purposes. One of the purposes that has been talked about today, and it is not part of the program, is to develop data on exactly the number of adverse effects that occur for a wide range of drugs. It's main purpose is

educational and as an early warning on serious reactions.

I think I will stop there and maybe Dr. Chevas would like to make a few comments and then, perhaps, some questions.

The Chairman: Dr. Chevas.

Dr. Chevas: Thank you. I think it's important to recognize that the central issue that we are facing today is that of severe adverse reactions to commonly used vaccines. Fortunately, these reactions are very rare and the net benefits of the vaccines in terms of preventing diseases greatly outweigh their drawbacks, but the reactions do occur and, for a few unfortunate children and their families who suffer the tragic consequences of these reactions, obviously, this is a matter of great concern.

I can speak as a parent in saying that there is probably no more tragic consequence to a family than a retarded child and, certainly, as a parent and as a physician, I feel great sympathy towards these families.

The real issue we are facing today is, what can be done about these adverse reactions? What can be done to identify them? What can be done to prevent avoidable severe adverse reactions? And what can be done to ensure adequate compensation for those children who suffer these rare severe adverse effects?

We certainly have sympathy with the motivation behind this proposed amendment; namely, to improve the reporting of adverse reactions. However, we have some questions as to whether this measure, an amendment to the Health Protection and Promotion Act, will effectively address the problem.

What we would like to do -- initially, what I will do is propose, in very general terms, three initiatives that we believe would make some impact on the central problem.

The first question: How can we best identify adverse effects?

There are a number of benefits to a program that would improve the reporting of adverse effects. Clinical trials which are used to test the effectiveness and safety of vaccines are simply not large enough to screen for the very rare effects, and a system of adverse reporting would be beneficial to accomplish this.

Second of all, an adverse reporting system would allow for an ongoing monitoring of vaccine safety, looking for any potential changes which might occur over time. Also, a system of adverse effect reporting would allow us to do some ongoing monitoring of the risk/benefit comparison of vaccines, which is particularly important if any of the

diseases in question become less common or the risks become less severe.

Is reporting to the medical officer of health the most effective way to accomplish adverse reaction reporting?

Certainly, there are some problems with this approach. To be effective, such a scheme must be centralized. There are simply not going to be enough adverse effects in any one of Ontario's 43 health units for any one medical officer of health to make good use of this data. There has to be, at the very least, an Ontario-wide registry of such effects and it has to go to a place that has the logistical support and expertise to follow-up on these reports to ensure that they are, in fact, adverse effects of vaccines.

The Ontario Medical Association has taken the lead in establishing a system of reporting adverse reactions to drugs, and we should point out that there are far more numerous and more serious adverse reactions to drugs in this province than there are to vaccines and we suggest that a similar peer-sponsored system has important advantages. In any case, it is simply not enough to add an amendment to a piece of legislation and expect that an effective reporting system will emerge spontaneously.

The second question: How can we best compensate the children who suffer from rare adverse effects of vaccines?

The Ontario Medical Association believes that Ontario should study seriously the establishment of a vaccine injury compensation scheme in conjunction with federal programs.

A compensation scheme would ensure that victims of vaccine injury receive adequate financial compensation and are not subjected to the lottery of the legal tort system. Compensation schemes are already in place in a number of European countries, and they have received support from a number of prominent expert medical groups.

The Third question: How can we best prevent avoidable adverse reactions?

Children who suffer significant adverse reactions should not receive subsequent doses of certain vaccines. Unfortunately, this may still sometimes occur. Is reporting of adverse effects under the proposed amendment likely to prevent this? Unfortunately not. There is no mechanism to get the detailed information to the physician who may be asked to give the next dose of vaccine.

We believe that it would be more effective to have an education campaign aimed at both public and physicians to re-enforce the information about contra-indications to subsequent doses of vaccine. Again, the Ontario Medical

Association would be happy to consider participating in such a program.

Let me reiterate that we feel that adverse reactions to highly beneficial vaccines are a significant problem. We feel that a more comprehensive strategy is needed than that that is reflected in this current amendment.

The Chairman: Would somebody else like to make any comments before we go to questions?

Doctor?

Dr. Hilliar: As chairman of The Public Health Committee, I would like to take the opportunity to thank this committee and, in particular, Mr. Pierce for bringing this very important and complex issue to the public attention, as indicated by Dr. Chevas.

The Ontario Medical Association has had this concern for some time now and, as early as October of 1985, made recommendations to the Minister of Health to investigate the adverse reactions and, indeed, to look at a study of the possible compensation program for children so adversely affected.

In general terms, the OMA supports any effort that is put forth to improve adverse reporting, as evidenced by our adverse drug reaction program. We certainly would support improvement in the identification of individuals adversely affected.

The Chairman: Dr. Gold, would you like to continue?

Dr. Gold: I guess, to pick up on some comments that were made about the benefits of the computers, one of the problems with the reporting system, if it's going to be sort of an ongoing surveillance to find out what's happening, is that you need not only the numerator; namely, the number of damaged children; you need to know the number of children who were vaccinated so that you can tell from one time period to the next the rate, as, really, the risk of the reaction always has to be a percentage or a rate, and this is one of the big problems.

As many people have already mentioned, documentation - who has the records of immunization? Where are they accessible? How do you relate an adverse reporting system to the background number of children being immunized? If you are concerned about a given lot of vaccine as perhaps causing more reactions, you very clearly have to know where that particular vaccine has been used.

So that, there are problems with this. They are not insurmountable problems. Vaccine reporting systems do

exist. I can provide very good data, but you have to look at what you want the reporting system to do for you in order to ask the questions you want to ask of it at the very beginning so you know how to design it.

The Chairman: Presently, what is the reporting on the numbers of vaccines done in the province? How does that work in terms of public health information? Do you know which kids are not being immunized and which ones are?

Dr. Chevas: We collect information under the Immunization School Pupils Act for children of school entry; so we have good information on children when they achieve the age of four or five or whenever they enter school and, by that time, with the vaccines they've received prior to that and with the catch-up which is done at that age, we've achieved very high levels of immunization, generally, in Ontario, but we don't have very good information on what the rates of immunization are in the first few months of life when pertussis vaccine is most beneficial and when, unfortunately, most of the adverse reactions seem to occur.

The Chairman: There is no reporting system at all offered for G.P.'s or pediatricians?

Dr. Gold: There is vaccine usage data for the amount of vaccine that is distributed by the Ministry of Health to physicians; so they know how many doses go out. They also know how many unused or expired bottles come back, or partially used ones that expire; so there is that kind of data. You know how many doses go out but we don't know how many of those doses end up in children's arms until they get to school or to day care, because, in licensed day care, there is a separate act that covers healthy children in licensed day care and their immunization records are also required. Unfortunately, in many respects, lots of children aren't in licensed day care; they are in informal day care arrangements that are not covered by the Day Care Act.

The Chairman: There are other facts or opinions that I wanted to know about.

You are suggesting, essentially, that, in your reporting mechanism, one of the problems is that of requiring centralization. Are you saying, or suggesting, something that needs to be considered in terms of the overall usage of the data or that the local OMA is not the appropriate vehicle through which to send on that information to a central data collection?

I guess I am wondering if you are talking about really serious concerns about where it starts out, what the process is or what the final repository is.

Dr. Chevas: I think the model that's been adopted for

this amendment is to use essentially the same recording requirements for vaccine reactions as are used for reportable diseases. If we look at why diseases are reported to the local MOH, it's because the local MOH, in most cases, is required to take some action based on those reportable diseases, whether it be to advise the parents about a quarantine period for the chicken pox or advise the family about the availability of hepatitis E vaccine or whatever; so there is a need for local information and only very secondarily does the MOH serve the role of then passing statistical information onto the province so the Ministry of Health can keep some sort of general idea.

In this circumstance, the same logic doesn't really apply. We're not asking the MOH to take vocal action in dealing with the vaccine problem; so I question whether, in fact, that intermediate step really is very logical or whether the model, the reportable disease model, is really the right one to follow up.

The Chairman: Can I just say to the members that there are matters, nothing which may be out of order, in terms of how broadly we can expand the scope of the bill. There are such things like -- the Public Education Program would be one such matter, but it is always possible for committees to report back to the House with additional information, and that would be one of the possibilities; not just having the bill go back but also saying, in addition to this, these following things should be done.

Mr. Pierce.

Mr. Pierce: Doctor, as you have stated, there is really no mechanism presently for reporting adverse reactions?

Dr. Chevas: Well, there is the mechanism through the Ontario Medical Association as a voluntary -- I'm sorry?

Mr. Pierce: It's not a good one; voluntary --

Dr. Chevas: It's a voluntary system. I wouldn't say that voluntary systems are necessarily less good or less efficient than mandatory systems. I think there are probably lots of examples where mandatory systems have not been terribly effective.

Mr. Pierce: One of the problems that I see in it being voluntary is getting doctors to recognize that there has been a reaction and, as you have heard many parents here today say, doctors are very reluctant to admit that there is a reaction, or an adverse reaction, and that there are other reasons why the child may be coming down with a high fever or responding to the vaccination at the same time as they are teething or having other personal problems; so that the

real voluntary reporting or acknowledging of the reaction isn't as strong as if it's required by legislation, or mandatory.

Dr. Chevas: Well, one of the problems which arises with the identification of vaccine-related adverse effects is the judgment as to whether the fever or problem, or whatever it is, is, in fact, truly vaccine related. The fact remains that incidences of fever and illnesses of various kinds are not uncommon in children of that age group; so a physician, in any case, is called upon to make some sort of a judgment, based on whatever guidelines he uses or whatever guidelines are laid out, to make some judgment as to whether the adverse effect is, in fact, vaccine related. That element of judgment would likely apply to a mandatory system just as it would to a voluntary system; so I am not sure that making it mandatory is necessarily going to get to the heart of the matter.

Mr. Pierce: Well, it may not get to the total heart of the matter, but it certainly makes it -- there is more strength in it. There is more commitment to do reporting than there is under the present legislation or under the present bill.

The Chairman: Dr. Krauser.

Dr. Krauser: Before the OMA started its Adverse Drug Reaction Reporting Program, physicians were asked to report to the federal government, and the amount of reporting that was done was dismal. One of the arguments for putting this into the OMA is that our members are more likely to report to us. They're more willing to; we are not government. We're much more flexible, much more able to announce and raise concerns about adverse effects at a time when it can't be nailed down; so we are much better able to act as an early warning and, number three, we are able to provide our members with information about adverse effects. One of the dismal effects of the federal program was that they were providing physicians with no feedback.

One of the things I think you have to seriously look at is the success of the OMA program as measured in terms of how sensitive we can make physicians to the adverse effects of the drugs that they use, how effective we are in raising their awareness to a fairly high degree so that they, themselves, are more conscious of what they are offering to patients in terms of risks and benefits and, mandatory or voluntary, our feeling has been that an aggressive approach through the Ontario Medical Association is more effective than anything else we have seen to date. That is the objective of the Adverse Drug Reaction Reporting Program and to make it through the MOHs or to make it directly to government, I think, it would lose that component. Dr. Chevas can comment on whether, in fact, you are going to get

a sizeable increase in reporting. But take us out of it and you lose the effectiveness of our addressing our members on the issues of adverse drug effects; so I would like you to be aware of that. That's an important component of the program.

The Chairman: Mr. Jackson.

Mr. Jackson: Well, if I could be allowed a supplementary.

Am I understanding you correctly that the adverse drug reaction monitoring that you are doing involves all ranges of drugs?

Dr. Krauser: That's right.

Mr. Jackson: Incidentally, this is the committee that did Bills 94, 54 and 55, so we have a fair working knowledge of those three areas which affected you.

The Chairman: Some of us have more than we would want. There are new members of the committee.

Mr. Jackson: And there are some of us who are still doing those bills until we get them right, Mr. Chairman!

But this issue of adverse drug reactions, I am trying make a distinction between that drug which is administered because society expects children to take the drug based on a certain amount of public perception and expectation and those drugs which are administered subjectively, in a sense, based on the diagnosis of a physician.

Now, I can't help but listen to your entire presentation and not feel that there has to be some room within your thinking that accommodates the very clear distinction between a vaccine which a two or three month old child is administered, of which the parent may or may not have a level of understanding or experience, and another drug, for example, where the doctor looks at an entire variety of circumstances before even recommending, and the pharmacist that's involved is a first line of defence in gauging reaction and then reporting to you; then you would check, I think it was, 5,000 or 6,000 adverse drug reactions that were unrelated to this vaccine in Ontario last year alone. I mean, that's a lot of reporting.

Dr. Krauser: Not reporting to us. Well, let me just -- I heard a figure quoted. Last year we had 2,054 reports to us of adverse drug reactions.

Mr. Jackson: On this?

Dr. Krauser: No. Vaccines, there were 113 reports,

87 of which were considered serious reactions. That was in 1986, January through September.

Just to get to your point, I think you would be hard-pressed to draw a distinction. After all, physicians were administering or recommending vaccines to kids before we had a mandatory program. I think it's reasonable to say that we expect our physicians to make judgments as to whether things are contraindicated or whether they are part of a provincial program or not.

Maybe Dr. Gold could comment further.

Dr. Gold: I would support you in the sense that there is whatever you call -- whether it's a philosophical difference or a difference of approach. The drugs are being given to cure a sick patient; sometimes to prevent illness but, usually, to cure something that's wrong. Whereas a vaccine we are going to prevent disease subsequently occurring and we are giving the vaccine to perfectly healthy children; so that approach is somewhat different. You give the drugs because the patient comments that something is bothering him; so there is this difference and it may lead to differences in --

I think the most important thing is trying to figure out what is the most efficient means of getting severe reactions reported. Whether it's through the OMA, whether it's through the Medical Officer of Health; whether it is compulsory or voluntary I think are issues that have to be resolved, and I don't know that you can write the bill that we can say what is the most effective system yet.

One of the things that I think you have to recognize with vaccines, even if we had an ideal, 100 per cent effective reporting system, vaccines are not 100 per cent safe, although, with future technology, we may indeed get to the stage of much improved vaccines, but I think we have to accept the fact that vaccines do induce usually complex biological reactions in people and, for the foreseeable future, there are going to be children and adults - we left adults out of all of this. Vaccines are given to adults and they do suffer adverse reactions at times; so you might want to consider that before you go travelling. I think the issue is reactions do occur and we are saying that the benefits for all of society of everybody getting immunized, unless there are reasons not to be immunized, are important. So, I think we can't just report things. We can't just have a compulsory immunization law without recognizing that there are going to be adverse consequences for some children. The dollars and cents, obviously, are not going to pay for the anguish and the suffering but, at least, families who are doing something with full knowledge, hopefully, if that can be obtained, are accepting the decision that it's a benefit for the majority that everybody is getting vaccinated and

that, if a severe reaction and permanent damage does occur, families shouldn't be left dangling to deal with that under our health system.

The Chairman: One further comment.

Dr. Chevas: It's very easy to, particularly when one has been listening to some of the terrible adverse effects which can occur, very rarely, from these vaccines, to fall into the mind set that, somehow, immunization is a burden that young children must bear for the benefit of society. You must remember that the greatest beneficiary of any vaccine is the child who receives it. Of course, any physician will make the judgment when he immunizes a child as to whether it is contra-indicated in that individual. But, in administering the vaccine, it is the child who receives it who is the greatest beneficiary.

Mr. Jackson: Mr. Chairman, my final supplementary and then I'll yield to the parliamentary assistant, but I want to get right to the meat of this, and I am having real difficulties with what I am hearing.

Again, based on all the hundreds of hours of deputations received on Bills 54 and 55 about the changes to the Drug Benefits Act and Regulations, it seems to me that there is a reason why we have not progressed to a point in dealing with this issue, as some other jurisdictions have, and that's been troubling me since I first heard about this almost a year ago. Then, having witnessed by deputation a lot of what goes on in the medical pharmacological world in Ontario, it seems to me that there are some elements to this issue which shouldn't go unnoticed.

One is the fact that in getting, or looking for, a pharmacological reaction, or an adverse drug reaction, the doctor is able to consult with the patient and the patient can verbalize and articulate what it is that's going on; there is an expectation that such and such will do such and such for you, and we know that, in the commercial world, which is governing drugs in the Province of Ontario, there are checks made that show the inability of a drug, in some cases, is as important as it's remedial effects, but in this case, we have an entirely different issue, where the child is unable to articulate the reaction and it is rather subjective.

As I say, having gone through it myself, no one said, we would like you to phone the health nurse each day for three days following the immunization of your daughter so that you can advise us of what was happening. I mean, we are graphing everything for my daughter, from the number of her toes, to the centimetres, to her weight. I mean, we are graphing everything, okay, and I am enjoying the whole exercise, but in no way was I told, and I don't wish to

burden you with the experience because you have gone through it more times than I have. I have only done it once, so far. It just seems to me that this is an entirely separate issue as to how the medical profession cooperates with the pharmaceutical industry which provides the serum and the state or government which sets the standard or allows or creates the tolerance level for it.

You know, we have got stronger legislation for gun protection in this province than we do for something which is mandatory and a risk for some of our children, and that's the point I am getting across. I understand adverse drug reactions. There's this notion that it isn't commercially viable. There is no pressure point in the system to improve the vaccine. No one is out there screaming for a better vaccine and, if it doesn't come internally from the doctors who are establishing the monitoring mechanism, then... That's the point I am trying to get at.

I was a little concerned that you were lumping adverse drug reactions into something which I consider to be rather unique as opposed to the normal pharmacological reactions which you, as physicians, know more about and have to cope with because you know how the drugs are tested in this country. You know the source of materials for the serum can come from any number of third world countries around the world, and we don't do batch checking.

There are a lot of concerns here, and we will be asking more questions in the future, but I clearly think there is a distinction here where the parent is given virtually no option, given how it is conveyed to them. I have read the pamphlet, which is good pamphlet except it doesn't tell you that there is a potential for death - it's not mentioned in here. I just read this for the first time. This is the one put out by the OMA. I just received your package today but, you know, it's not mentioned there, and I think a child is in an entirely different situation than the medical profession; there is an incumbency upon you to develop a reporting mechanism which will help put the pressure points in the system to force either the government or the drug companies... I don't wish to embroil the physicians in the equation, but I think that your natural advocacy role is being downplayed here.

Dr. Krauser: If I make this comment.

There is no problem at all. I agree absolutely and, if we fall short on that, I am quite sure the critics will indicate it to us. There is no question that we can count on our Public Health Committee, and we have consultants, like Dr. Gold, and the kinds of critical comments that we can expect from our members if we are falling short. We count on that nexus of people to make bloody sure that, if there are gains to be made in improving the safety of the

things that we do - procedures, drugs; immunization products - that we get that identified for us and that we carry it out. There is no question about that.

If there are gains to be made in terms of safety of the product that are there to be made and only need a reporting mechanism that shows the increasing number of kids who are not protected against pertussis or any other thing, then that's our responsibility to carry that out.

The Chairman: Dr. Gold.

Dr. Gold: Just to clarify a few things. One, I think, yes, there is a difference between the vaccine in the young child where you are having a third party, namely the parents, interpret what happens compared to a drug in an adult, that a vaccine in a child in that sense is no different than a drug reaction in a child because you, again, you are depending on the parent to interpret what's going on in the child subjectively.

Just to clarify, though, the business of where our vaccines are coming from, all vaccines have to meet federal licensure requirements of the Health Protection Branch. The only vaccines marketed in Canada, as far as DPT, are now all manufactured by Connaught except -- and this varies from one year to the next whether one of the American companies also wins a provincial or federal, if it's in the group line.

So they are all meeting both U.S. or Canadian vaccine. Our Measles, Mumps, Rubella is all from one source at this point in time, namely the U.S. manufacturer, so that we're not using foreign vaccines at least for the childhood vaccines.

Mr. Jackson: I am sorry, I didn't mean the actual --

Mr. Gold: Each vaccine has to meet the same standards.

Mr. Jackson: The component chemicals that make up the compound could come from Thailand or so on, but they are still --

Mr. Gold: Not as available?

Mr. Chairman: You have to distinguish between vaccines?

Mr. Jackson: All right. Well --

Dr. Gold: That is one distinction with the vaccine.

Mr. Jackson: All right.

Dr. Gold: I agree; with the drugs we may not know where it's from.

Dr. Hilliar: I'd just like to make a point that some of the difficulties that sometime get amiss in this type of discussion and that is what we are asking is for the physician to look at the symptoms or problems and developing a cause/effect relationship. And that is a very, very, very, very difficult decision to make.

Perhaps when you're looking at a seizure or a convulsion or something that is a little more overt and you've got a good timeframe and so forth with good knowledge that the child had, or the individual had, some sort of an administration of the vaccine, then it becomes a little easier to develop a cause and effect relationship.

But when you've got a child with irritability, crying, a high temperature, we're asking the physician to make a decision at that point whether that child should indeed, whether that is, first of all, an adverse reaction to the vaccination, and secondly, whether that child should not go on to receive the series of vaccinations which are required for the immunization process.

If a physician elects prematurely to stop the vaccination program, he's putting that child at risk for developing the disease. We know statistically that that child, if he does develop the disease, 1 out of 250 will die. 1 out of 2,000 who get the disease will have brain damage.

The risks are far greater for that physician to make that decision. So, it's not black and white. It is very difficult. It is important for the physician to know the family, to know the parents, to educate the parents, and to know the child and to know what is happening with the child. But it is not a very easy decision to make.

Mr. Chairman: How many cases of whooping cough were there in Ontario last year or the year before; whatever we have the latest statistics on?

Dr. Gold: I don't know the nation-wide total. Usually somewhere between 2 or 3,000 reported cases. We know there are more than that because we know reporting is very incomplete.

Mr. Chairman: So Ontario would have its 40 per cent?

Dr. Gold: Yes.

Mr. Callahan: Mr. Chairman, I --

Mr. Pierce: --reporting mechanism is there to know

what --

Mr. Gold: That's exactly what the recording mechanism --

Dr. Chevas: And the adverse vaccine reactions to the one which is incomplete for the disease itself.

Mr. Pierce: Any more than we don't know how many adverse reactions there are because the reporting system is so bad that we don't know.

Dr. Chevas: Well, except that we have other provinces in Canada and other jurisdictions in North America that have much more complete recording systems. For instance, there's provinces like Alberta that have a publically-administered immunization program. So we do have them as a benchmark to indicate what we think the approximate number of cases, and there's general agreement in those jurisdictions as to what the number of severe adverse reactions would be.

Mr. Callahan: Mr. Chairman, I want to thank you because I have to go to the Board of Internal Accounting on the Health Committee Budget, but some of the information I've heard from the parents are that between shot one, shot two, and shot three, that if you have a reaction or something that is made known to the doctor, then going on to shot two probably just enhances the possibility of that child being seriously injured as a result of that vaccine; is that not correct? The greater the build-up in the child's body, obviously the --

Dr. Gold: Well, since we don't know what causes the adverse reaction in terms of the severe neurological complications, which is what we're concerned about, we have a good idea of why children get fever with the pertussis vaccine and some of other reactions.

I think because we don't know the strict cause and relation; we don't know that it's a dose response, that's why, for example, there's no data that really says that the Lily vaccine is any safer than the current vaccine. Yes, it caused fewer fever, it caused less local reactions, but we had absolutely no idea whether it was as safe in terms of the severe neurological damage.

And the same thing has to be said for the current a-cellular vaccine; we don't know. There are fewer of the so-called minor reactions with that vaccine in terms of the fever, the irritability, the local reaction than with the wholesale vaccine.

The Japanese data would suggest, given at two years of age, they're seeing as many claims for brain damage as they saw with the wholesale vaccine at age two. So we don't know

that it's much safer until we have a better idea of what, indeed, might be the cause.

I think when you have an unknown like this, what it means is if a child has what are recognized as severe reactions; namely, the prolonged crying, the shock or collapse-like reaction, very high fever, a seizure or any other significant neurologic reaction, then they should not get subsequent doses of the pertussis vaccine.

Not because we know at this point in time that they are at greater risk; they may very well be. But because we know that there is an association between the two; if it's happen once, you don't tempt fate and do it again.

And I think this should be very clear. We tried to get that message across, whether it -- obviously from the parents' stories today that message in the past has not gotten across to physicians as well as it should be.

Mr. Callahan: But surely the question that should be asked by the physician giving the second shot is a series of questions saying, "What happened the first time?"

Dr. Gold: Well --

Mr. Callahan: Well, can you tell me anything? Did the child scream? Did the child sleep inappropriately, and so on, before the second shot is given.

Dr. Gold: Right.

Mr. Callahan: And that implication, if the answers are "Yes. Yes. Yes" to some of them, either that shot shouldn't be given or -- certainly that should be put in a form and put on to some retrievable, technological unit that could be retrieved by any doctor later on in life or even on the third shot. But apparently that's not being done.

Dr. Gold: I can't answer as to how much is being done, but I know what is being done in my colleagues' offices and it is being done, at least with the physicians I'm familiar with. Obviously, it is not being done everywhere all the time. Immunization record keeping is a big problem and I don't know that --

Unless computerization has certain benefits, you also have the problems of confidentiality of medical information. That can be overcome, I'm sure, because immunization records have been one part of the medical record that has been successfully computerized in various parts of the world, and it is a very useful way of doing it.

Mr. Callahan: But surely on the first shot -- Like, you normally get on the first shot of anything other than, I

suppose, vaccines, they'll say, "Are you allergic to anything?"

Of course, on the first shot the parent would have no idea whatsoever if the child is allergic, but certainly on the second shot. And that's what I was getting at with the increase and the strain as you give the three shots, that if on the second shot it was made mandatory that the doctor ask a list of a series of questions and from that form an opinion as whether or not the child was reacting adversely to the shot. You would have saved the damage that at least some, if not all, of these parents have suffered or children have suffered.

Dr. Gold: Well, I don't think we have enough, I don't think we have sufficient information to say the risk is any less with the first shot than with any subsequent shot. But I agree, and in all the published information, a severe reaction with any of the doses of the vaccine, of any vaccine, is a contra-indication to giving that vaccine again.

Now, I don't think you are going to get much support by saying doctors have to ask a certain series of questions every time they see a child. I don't think the OMA would support that certainly.

Mr. Callahan: No, no. But if they're coming in for the second shot --

Dr. Gold: There should be a standard approach to how to give immunization, including asking what happened with the previous shot, knowing what the severe reactions are and asking if any of them occurred. And I think that should be standard medical practice.

Mr. Jackson: I think I'll add one more graph when my daughter goes in next time.

Mr. Callahan: I have got to go, Mr. Chairman.

Dr. Hilliar: One point, again, to add further to Dr. Gold's discussion here is the recognition and the identification of what's adverse and what isn't, what was just a normal side effect which is to be expected versus something that may indeed, with a subsequent shot, become much more serious. And this is where the difficulty lies within the science, to be able to identify that.

Mr. Chairman: Ms. Hart.

Ms. Hart: Part of my question has been answered, but I wanted to know if the OMA, or if you know if any of your members have done any work on safer vaccines. And I give you the background; I mean, if the vaccines are coming from

very few sources and those sources are all being sued because of liability, there is some -- to make them come up with safer sources - or not safer sources - but safer vaccines. Do you know if that is...

Dr. Gold: There are two sticks. One, if the drug company increases its price threefold that it's charging to the various provinces in order to cover their own liability; that is a stick, too, that can work both ways.

Mr. Jackson: Which is happening.

Dr. Gold: Oh, I know. It's happened. It works both ways, obviously. There has been a major drop in the number of - in North America - of the number of manufacturers involved in biologics, in vaccine production. And for some of them we have a single source; one company is the only source that's making a vaccine. And that's a problem. There are other sources around the world, but it's a real potential problem.

Yes, whether individual OMA members, I can't speak for, or people involved in testing vaccine... Well, Connaught is studying the acellular vaccine. There are large trials in the U.S. and IH-sponsored, looking at the acellular vaccine. One of the Japanese products is a single acellular vaccine. There are 12 different ones in Japan. One of those is in progress of a field trial in Sweden, comparing it to the standard vaccine, to see how effective it is, giving it -- and safe, when it is used in infancy.

So that studies clearly are going on. I think there are advocacy groups such as the National Advisory Committee, the Canadian Pediatric Society that clearly are very interested in promoting safer vaccines as they can be made.

I think we are in the midst of the so-called molecular biology revolution of how we're understanding to produce various things. We will see a lot of new vaccines over the next five to ten-year period of time with the possibility of -- as we understand what part of a given bacteria or virus is important for inducing immunity and protection against infection. Then we're really getting the technology to say, "Okay, let's get that part out of it, make a vaccine out of that and get rid of anything else that might cause side effects."

So, yes, there is research going on. I can't speak to whether specifically the OMA. No, because the OMA doesn't sponsor research in that format, but certainly OMA members wearing other hats are involved.

Ms. Hart: One other question. In countries such as the UK where the use of the pertussis vaccine has -- there has been a diminution in use of that vaccine. Do you know

if there has been any greater incidence of whooping cough, the disease, and mortality as a result?

Dr. Gold: The vaccine usage started falling dramatically in '74, '75 after a lot of adverse publicity in the media about the dangers which, initially, were being quoted as 1 in 3,000 children being brain damaged from the vaccine. And vaccine usage plummeted although it was not uniform. In some countries they still were able to maintain high rates.

They had their first whooping cough epidemic between '77 and '79 with an estimated 200,000 cases, 36 deaths directly attributed to whooping cough due to -- by the death certificate being signed out as a case of whooping cough. When you look at the mortality rate in infancy due to all causes of lung disease, pneumonia, where it wasn't specified whooping cough, then during that epidemic there was an excess of about 3,000 cases of children, infants, dying of respiratory diseases during that whooping cough epidemic.

In the absence of other known epidemics they had, during the third sort of epidemic, a smaller rate because immunization rates are going back up in England partly because of their experience with whooping cough in current times, partly because Prince Willy got his vaccine, and Princess Diana and Prince Charles have been advocating immunization of kids; that might have something to do with it.

It is not unique to the UK and Japan. A similar circumstance emerged where there were two deaths temporarily related to whooping cough vaccinations, and the government put a temporary hold to try to investigate what had happened and then decided to go ahead with their routine schedule which was at two months of age. Parents were afraid of the vaccine and immunization rates dropped.

They then switched to two years as their time of routine immunization and got very good immunization rates again, and they don't see much whooping cough in children, two, three, four, five years of age. They see the same amount of whooping cough in the zero to two years of age as they did before they had any vaccine progress. So by delaying vaccination, you certainly increase the risk of the infants getting the disease. And then subsequently they switched to the acellular vaccine at two years of age.

They are doing studies in Japan, already have some published on a small scale, on safety in young infants, but they haven't made any policy decisions yet to use the acellular vaccine in younger children.

Ms. Hart: Is brain damage one of the possible results of whooping cough?

Dr. Gold: Yes, it is.

Ms. Hart: Thank you.

Dr. Gold: And the number quoted of 1 in 2,000 is if the child gets whooping cough in the first six months of life, then the risk of brain damage seems to be - or the first year of life - from the British experience in their epidemic, was approximately 1 in 2,000 ended up with the brain damage.

Mr. Chairman: Mr. Pierce and Mr. Reyecraft.

Mr. Pierce: Doctor, a couple of short questions. In your comments, you said that a reporting system would require an Ontario-wide registry. Do you see that as a problem? Is it a problem that we just can't set up that kind of a registry in this province?

Dr. Chevas: No. The only reason this statement was made was that my reading of the proposed amendment did not seem to be proposing that. It was local reporting, based on the reportable disease model, and I questioned whether that was really going to accomplish this.

Mr. Pierce: Oh, I see. So it was really the paragraph in the amendment that made it more definite as a local registry as opposed to being a provincial registry?

Dr. Chevas: That's right.

Mr. Pierce: The intent of the bill is to be a provincial registry. So that if you're transferred as a doctor and you have your child inoculated in Toronto and you're transferred to Thunder Bay, then that registry, of course, is available to the doctor in Thunder Bay as well.

Dr. Chevas: Provided the doctor has ready access to that information--

Mr. Pierce: Yes.

Dr. Chevas: --in a very brief period of time. The vaccines follow at two-month intervals from childhood, and I am not convinced that there is a satisfactory mechanism for the second doctor to access that information quickly and efficiently.

Mr. Pierce: And certainly it was never suggested that the bill is perfect in content, but the reason for these kinds of gatherings is to try to draw out from people that are in the field, their expertise in making the bill more perfect than what it's designed to do.

Dr. Chevas: Well, I think, clearly, unless you're

prepared to put a computer terminal in every doctor's office so they can access that information quickly, it is going to be very difficult.

And keep in mind one of the additional problems that the doctor is faced with: A child who arrives in North Bay having receiving his first dose in Toronto and that doctor wishes to retrieve any information about adverse effects. He's going to have to send that child away, retrieve the information, which may take days or weeks before that information is set up, and it would depend on the parents bringing the child back yet again for his immunization.

And one of the problems we still face with immunization is some children whose parents don't bring them back on schedule -- parents who are not conscientious and don't bring their kids back for immunization.

Mr. Pierce: But I think, again, in the presentations that were made here, today and certainly comments by many of the parents is that there is a reluctance on the part of the doctor to recognize that there could have been actually a reaction to the inoculation or to the vaccination, and there is more emphasis placed on the fact that the child could be suffering from other problems, such as teething or a cold or something else, but to try to get away from the fact that it may have been related to the vaccination or to the drug.

So that there is, with that kind of a -- with that kind of thing happening between the doctor and the parent, it's natural to assume that it's never going to be entered in the record - even the child's record - that there has been some sort of a reaction.

When you hear parents tell you that they sat up for 13 hours with a child that was screaming and didn't respond to any form of sleep and just reacted violently or hysterically and the doctor says, "Well, its a problem that -- It's just one of those things. Don't worry about it." That's not entered on the record of the child.

And when the parent goes back in to see another doctor in another area two months later and said, "This is how my child reacted the first time." And even if the doctor pulled the records of the previous doctor, if they were available, there is not going to be anything on the record.

Dr. Chevas: I don't disagree with anything you've said. I think that certainly, in determining that any event in childhood is a reaction to a vaccine or not a reaction to a vaccine, requires a judgment call on the part of physicians, and physicians' judgement is not always perfect. There are many examples that parents or others can cite where they would question the judgment.

I think that brings me back to the point I made in my

opening remarks, that I think it's very important that we educate physicians - that's certainly a very viable role for the OMA to play - but also parents about what these adverse reactions or what these contra-indications to second and third doses of vaccines are, so that both would serve as better protectors of children who may, in fact, be put at risk from subsequent doses.

Mr. Chairman: Go ahead.

Mr. Krauser: I think there is more that we can do in terms of raising physicians' awareness of adverse reaction to this product that we should do.

The other thing that you have to keep in mind is what Dr. Hilliar said. If the physician errs on the side of not giving the shot, he's putting the child at increased risk. So this is what we count on our professionals to do, is to apply professional judgment on behalf of their patients. It's not just a simple equation.

The third thing I'd mention to you, instead of provincial reporting, one of the things the OMA is doing through its Child Welfare Committee, is developing a portable child health record.

There is a portable immunization record which is a card. What we have developed and are planning to test is something a little bit more extensive. It puts the onus, basically, on the parent to record the information, and responsibility on the parents to be knowledgeable about the child's health so that they can, in fact, cope with the situation when they're being treated - the child is being treated - by a physician they don't know. So that's just another way of approaching that same kind of problem.

Mr. Pierce: But, again, getting back to the educational process that -- and that's in educating the doctors and the parents in what is a reaction, and getting both parties to admit that there has been a reaction and that it is documented. Because if it's not documented, if it's only an agreement between the parent and doctor, that, "I believe that your child had a reaction but I just can't put it down on paper," then even having a child card or a child medical record accompanying the child doesn't do a thing for us. So, it's back to the educational process.

But, let me just continue on because I know that we're going to run out of time here. And one of your other comments that you made in your presentation, and that was that the OMA has taken the lead or a lead in reporting adverse reactions.

Dr. Chevas: Yes. Well, in an article that was published in the - I would assume it's the Vancouver

Citizen - on January 27th, 1987, it says that:

"The system for monitoring adverse reactions to vaccines is so inadequate that health officials don't know exactly how many children are actually injured by the shots. Ontario, Quebec and the Maritime provinces do a particularly dismal job of reporting adverse reactions, ranging from fevers to brain damage, to federal authorities."

Maybe I'm talking about different drugs than you are.

Dr. Chevas: Well, I'm talking about the OMA taking away the general reporting of adverse drug reactions, which includes vaccine reactions. I would not for a minute, as I said in my opening remarks, I would not for a minute argue that we have an exemplary or perfect system of recording adverse vaccine reactions. That's why we, in fact, were very complimentary about the motivation behind the Act, because we feel that a method to improve that reporting would benefit everyone. Our criticisms were focused not on the spirit of the Amendment, but on whether, in fact, it really is going to practically address the problem.

Mr. Pierce: Let me follow with another question then. You also, in your remarks, referred to compensation. And both the federal and provincial governments are studying a possible compensation package and, I would assume, a no-fault compensation program to begin with, to start out with. Do you think that if that mechanism was available, a no-fault compensation program, that there would be less reluctance on the part the doctors to recognize possible reactions?

Dr. Chevas: Well, I'm not for a moment going to suggest that doctors don't record adverse reactions because of any legal liability that might be accompanied there, but it certainly would not be a disincentive to them if any possibility of legal liability is removed.

Mr. Krauser: But I am not sure that it relates to a decision of a particular office, whether the patient's description of what happened with that child gets factored into the equation of whether you do your next shot. I am not sure a compensation program would impact greatly on that. I think it's our responsibility as the OMA to sensitize physicians so that they can carry out their professional education to assess that better.

Mr. Pierce: You don't believe that there is any reluctance on the part the doctors to report a reaction because of the threat of a lawsuit or litigation?

Mr. Krauser: Well, we checked that out. There doesn't appear to be any major concern from the CMPA about

that sort of thing. I mean, after all, we get 2,054 reports.

Just take an example, if you want something between a contrast media which has to do with - its not immunization and it's not a therapeutic drug - contrast media 222 reports 39 serious including one fatality. There is a whole list of the fatalities related to each classification.

No, I think physicians -- I mean, our program wouldn't go for 15 minutes if we were putting our members at risk. What you're getting out of the profession when you get this kind of a reporting is a serious and sincere attempt to identify this information. We are the only division in Canada that does this; no other province has the program.

And I think if you talk to physicians about the OMA program, you'd find a fair degree of respect for it. And, in fact, it's developing information that you wouldn't get otherwise, and feedback you wouldn't get otherwise. So this is something I think that it is in our interest to build on.

Mr. Pierce: Let me just ask --

Mr. Chairman: If you want, we'll continue overtime if we can, but Mr. Andrews has been on the list for a long time. Mr. Cordiano has brought a request to my attention as well. Mr. Cordiano?

MR. CORDIANO: Just a brief supplementary going back to Dr. Krauser. He was talking about the physician erring on the side of actually having the vaccine administered. The doctor has no way of knowing, if it's the first shot, what might happen to a particular child. I mean, there is just no way, is there? Is there any way of determining what the reaction might be with any child that walks in?

Dr. Gold: It depends on what type of reaction you are talking about. In terms of the severe neurologic reaction to pertussis vaccine, no. There is a slight, but perhaps real - we don't know because the data isn't good enough - risk, and any child who has had a seizure before is likely to have seizure if you do anything that increases the likelihood of a seizure. So children who have had seizures before may be at increased risk of having a seizure with the pertussis vaccine. Children who, when they eat eggs, have severe allergic reactions may have a severe reaction if they get the measles or the mumps vaccine, which are grown in duck embryo tissue.

So that there are certain things that we know will predict. Unfortunately, we don't have either a question

to ask or a laboratory test that we could do that are going to identify the children who have severe reactions to the pertussis vaccine.

Mr. Cordiano: So, in fact --

Dr. Gold: So the first time around you don't know, in terms of screening out children who will be at risk.

Mr. Cordiano: So what you're telling me is that you can't even reduce the chances further in the first instance?

Dr. Gold: With the pertussis vaccine, no, except the issue of: Do they already have a seizure disorder, then they are more likely to have a seizure with the vaccine.

Mr. Cordiano: Would that be something that's fairly common, since I don't have children of my own yet? I mean, do parents have an understanding about the vaccine and the kind of reaction? Do they have enough information, in your opinion, to determine even that, let alone all the other --

Dr. Gold: Whether their child has had a seizure before?

Mr. Cordiano: What I'm saying is that, given the fact that it's only three months old, this child -- and if it has an allergice reaction to say -- I don't know what. You said egg.

Dr. Gold: Okay. But, fortunately we don't give that vaccine until they're over a year of age, at which point, if they're going to have an allergic reaction - a severe allergy to eggs that would cause them a problem with the vaccine - we should know about it by then.

The problem with giving the vaccine at two or three months of age - the DPT polio - is that, yes, we don't know very much about that child yet. And therefore you have to ask the question: Well, is that unknown risk great enough that you want to defer vaccinating the children until they're of age.

Well, if you defer the vaccination, we really have not data to say that vaccinating at six months is any safer at all than vaccinating at two months. The British data on severe neurologic illnesses in children is no different than our data. Most of it appears in the first six months of life, whether you vaccine them starting at two months or you vaccine them starting at six months. That's when unexpected neurologic illnesses start making its appearance, that you didn't expect, based on the

child's condition at birth.

One of the problems with vaccine reaction is we can't predict what's going to happen. You have to say: Well, what's the risk of allowing children to remain unimmunized since we know there is pertussis in the community, and they would therefore be at risk of getting it? And the medical authorities, certainly in Canada and the United States and most other authorities in Western Europe, feel that you immunize children starting at two months of age and certainly, on a world-wide basis, the WHO approach around the world, because the disease is so severe early in infancy, you want to get the kids immunized.

No one can predict enough about a two-year old to know what's going to happen to them six months from now.

Mr. Chairman: A two-month old?

Dr. Gold: Oh, a two-month old. We don't know. Not enough has happened. We don't know how to diagnose many conditions even that are present at birth because you're not sure about them until the child is three, four, five, six-months of age.

Mr. Chairman: But, if you --

Mr. Cordiano: Sorry, just one final question. If you allow a year to go by, you're saying that that won't change very much the chances of knowing something more about that.

Dr. Gold: No. By a year of age, you will know most of the conditions of health that are going to affect that child. Not all of them, obviously.

Mr. Cordiano: But you're increasing --

Dr. Gold: But you're certainly increasing -- By delaying the immunization, you're putting the child at risk of getting the disease at the worst time of life when he's at greatest risk of having severe illness and damage from the disease.

Mr. Chairman: Mr. Reycraft.

Mr. Reycraft: Mr. Chairman, Dr. Gold, did I understand you to say that last year there were 113 adverse reactions reported, of which 86 were deemed to be serious, or was that 87. Were all of those reactions to the DPT-Polio vaccine or was it more general than that?

Mr. Krauser: The information I have doesn't tell me, and the fellow who does this work has gone to Florida.

So I was not able to break this down for you, but I think that's something we can do.

Mr. Chairman: That would be very useful.

Mr. Reycraft: Well, I would be interested in knowing more about that figure and whether any attempt has been made to analyse it in terms of the physicians that were doing the report. I would like to know whether there is any pattern, in terms of geography, in terms of whether or not there were G.P.s or perhaps pediatricians to whom parents might have gone after there were some symptoms of an adverse reaction. And there was something else in my mind too, Mr. Chairman, but that's gone now.

Mr. Chairman: Dr. Krauser?

Mr. Krauser: Yes, Mr. Chairman.

Mr. Chairman: I'm sorry. Mr. Krauser.

Mr. Krauser: I can tell you that if, in fact, we're out to find out if there are adverse reactions in a particular batch, then I think we would have to know something about the geographic location. I would suspect we probably don't, but maybe Dr. Carlton probably knows a little bit more about how we manage this. But I can tell you, in terms of identifying individual physicians, individual physicians report, but so do nurses and dentists and a lot of other people report.

It's a key to the reporting that you don't get into the business of trying to identify whether the physician is severely incompetent or something like that. You just simply can't do that from central OMA and it is counter-productive. If we see something that is really difficult, then we have to do something.

But on the whole, this program aims at getting compliance from physicians until we get enough information. And giving them an educational response, talking to them directly, pointing out some facts about the adverse reactions, publishing stuff in the drug report, it's that kind of program. We have the same kind of program with maternal deaths.

We simply are not the College of Physicians and Surgeons, which is not to say that we can't be influential, but that's not our area, and we have no authority to go after the individual physician.

Mr. Reycraft: Well, I wasn't looking for incompetence. I am just trying to determine whether or not there might be groups of physicians who are more inclined to report than others.

Mr. Krauser: I could find out, because we have information, but I don't have it here.

The Chairman: Dr. -- I'm sorry. I keep giving you either an M.D. or a Ph.D.

Mr. Krauser: It's just an M.A.

Mr. Chairman: Sorry.

We normally would rise at five, but I'm in the hands of the Committee. I have other people who wish to ask questions. Are they questions that you want to go to the OMA, or are there any questions you were going to ask the ministry people tomorrow? Mr. Baetz?

Mr. Baetz: Just one question on reporting. You cited, I think, several provinces - in particular Alberta - that has a universal mandatory reporting system?

Mr. Chevas: The entire system of vaccine immunization delivery in Alberta is different. It's done through public health clinics, which is very different from Ontario where almost all of the vaccines are given by independent practitioners.

So certainly one of the advantages of a public health system is that reporting of adverse reactions seems, based on the Alberta example, seems to be more complete. But there are a lot of other issues, of course, which that raises, which I don't think we have time --

Mr. Baetz: Well, I'll take that, then. It would appear that the system used in Alberta reporting is more complete than, say, it is in Ontario?

Dr. Chevas: Our feeling is that the reporting for the severe reactions, the completeness of reporting seems to increase with the severity of the reaction. I think that's generally true for most diseases, and I would expect it is true also for vaccines.

Mr. Baetz: I guess what I was trying to really get at is to compare the Ontario reports of incidence of severe reaction. Compare that to Alberta because you do know that there is a certain incidence of this right across the population. I think what you can really compare are the two systems. I mean, is one perhaps more accurate than the other?

Dr. Gold: Let me answer that. It gets back to knowing the numerator and the denominator. The system works well in Alberta because they have a smaller group of people, namely the public health nurses, to train and

educate to: One, inform the parents, and then to ask questions of each subsequent visit. If they don't get a telephone call, to find out, and then fill out the form reporting the reactions.

In addition, the immunization rate records are computerized in Alberta. And the way they can then study and confirm severe reactions is to look at hospitalization discharge diagnoses at given ages, and see a child admitted for an encephalopathy or severe neurologic illness. They then, by computer, can find out: Well, what's the immunization history of that child? and check the medical records.

So the whole system is sort of complete in Alberta and gives them a way of looking at it that we don't have here. We can do some parts of it, but we don't have the immunization records accessible and we don't have reporting of reactions the way they do in Alberta.

Mr. Baetz: So I guess, getting back to this, that because of the system here and its inadequacies that you have referred to, the reports that we have on severe cases is not - you would say - is not really --

Dr. Gold: I can't tell --

Mr. Baetz: It's likely that -- It could be; maybe isn't, but there's no way of knowing. There's no way of knowing.

Dr. Gold: Yes.

Mr. Chairman: Mr. Andrewes?

Mr. Andrewes: It raises another issue, Mr. Chairman, even though it's past our normal adjournment, and that is the whole question of -- You talked about the benefits of the Alberta system, which is a government-controlled immunization program. Would you tell us about the disadvantages, if there are any. And I know this perhaps is outside the scope of the Bill, but I think it's important we --

Dr. Gold: The major disadvantage, I guess, or potential disadvantage I see is what, in a sense, fragments the continuity of care. It takes immunization away, out of the doctor's office.

Now, it varies. Obviously, it's a bigger problem to big cities than in many of the smaller communities where the physicians know the public health nurse and see her every day and find out about things. So it's a varying problem. But administered, from a structural point of view, administratively, it separates out vaccine and the

doctor gets the reports and knows what happens, and gets the immunization history, but he's not as directly involved.

Other disadvantages, I think, are very hard to assess, because I'm not sure of if you say immunization is essentially a public health approach to controlling disease and reducing health care costs, then shouldn't the public health division be in charge of it?

Alberta has said, "Yes." As to the other provinces, some have a mixture: some of it public, some of it private. Ontario is mainly private, but there is the school program, catch-up programs, which are often organized at the public health level.

I don't know that we have an answer as to which is the best system. Alberta obviously provides -- that kind of a system allows you to get results about your program much more readily than when it's all done in individual physician's offices.

Mr. Andrewes: So there are both ideological arguments and medical arguments for and against that kind of system. And at the risk of sort of making those comparisons because we often find ourselves making comparisons from province to province, I would think the Ontario situation would be tough to compare with Alberta.

Dr. Gold: Very tough. We have a much more diverse population here, too, in terms of their population; and it's bigger, which creates problems.

Mr. Chairman: Mr. Jackson?

Mr. Jackson: Thank you, Mr. Chairman. Currently when I take my daughter in for her first inoculation, the physician is able to charge OHIP for that visitation, correct?

Dr. Chevas: I must say it has been a while since I've been in private practice.

Dr. Gold: I'm sure that he can bill OHIP for that.

Mr. Jackson: Well, I get my two well-baby visits a year; right?

Dr. Gold: Well, it should be.

Mr. Jackson: Okay. Well, the second question: If my daughter has an adverse drug reaction and I phone the physician the following day, and I consult with him on the telephone for a brief period of time, is the physician able to bill OHIP for that?

Dr. Chevas: Physicians can, on my understanding - again I'm not an expert on OHIP billings - but my understanding is, no, they can't bill for telephone conversations.

Mr. Jackson: If, then, I requested my physician to record that in my daughter's records, would they be able to bill for that?

Dr. Chevas: I must say I'm not perhaps the right person to be asking. My understanding is that most conscientious physicians record what they discuss with patients on telephone conversations, so the physician would, in most cases, make a notation in their record. But my understanding is they can't bill for that.

Mr. Jackson: Then let me reverse the question. Are they obligated to record the conversation anywhere on their records? Is there something within the College of Physicians and Surgeons in Ontario?

Mr. Krauser: It is a reporting requirement under the Health Disciplines Act. For services which you provide, certain information has to be recorded and has to be kept for six years.

If you look under the Health Disciplines Act, in the parts related to medicine in the regulations, there is a requirement to record information about services provided to patients, and physicians are obliged, under the same legislation, to hang on to that for six years.

Mr. Jackson: And the parent has absolute unfettered access to that record up to the age of 60?

Mr. Krauser: Well, no. You get into a lot of other issues about going to the records. Parents certainly have access to the information in the chart, but when you're recording along with immunization something else about marital disharmony and that kind of thing, it makes it difficult.

Mr. Jackson: I want to narrowly confine it in the context of my consultation the night after I'm telling the doctor about my adverse reaction in my daughter. And I now know that if he talks to me on the phone at any length, he may or may not - probably not - be compensated for that conversation. My understanding from some depositions is that it not always has been recorded, but you're telling me that, in fact, it should be recorded.

Mr. Krauser: Well, just as a layman with what I know about the OMA and the way physicians work, I would expect that a physician who had information that was related to the decision to have a second shot, you know, for the parents, would record that somewhere so it

wouldn't get lost. It just makes sense.

Dr. Hilliard: Yes. The Medical Protective Association does present guidelines to physicians in the type of documentation that should take place between doctor-patient information.

Mr. Jackson: Okay.

Dr. Hilliard: So there are a number of guidelines that physicians do follow.

Mr. Jackson: With respect to disclosure?

Dr. Hilliar: With respect to documentation.

Mr. Jackson: Documentation.

Dr. Hilliar: Yes.

Mr. Jackson: And finally, if the nurse --

Mr. Chairman: Is this another short question?

Mr. Jackson: It is a very short question, Mr. Chairman. The question of whether or not the nurse or the health nurse takes the call. We were formerly going to an HMO and we cancelled that for a variety of reasons, but is the nurse allowed to record anything in the file?

Dr. Hilliard: Yes, indeed. The nurse would equally have nurse-patient responsibilities in documenting information regarding patient care.

Mr. Jackson: My final question, Mr. Chairman, is equally short. This is a real simple one. Do you have any recommendations for amendments to the Bill as you have seen it presented to you?

Dr. Chevas: I think that we have not drafted out any specific amendments that we would place into the proposed amendment. I think that our feeling is that -- I mean, that as we studied - and I gather there have been some changes made since even that time - I think we have pointed out what we think the deficiencies of that proposed amendment are in terms of addressing the problem that we all agree that we want to address.

I think that if this committee seriously wants to look at those issues that I laid out in my opening remarks, then they have to take a much more comprehensive look at the whole issue of reporting, follow-up and compensation. The three issues really are hand in hand, and I'm afraid that a simple amendment of this sort really isn't going to address the problem adequately.

Mr. Jackson: Yes. So a short answer is, 'not at this time'.

Dr. Chevas: I guess so, yes.

Mr. Jackson: For the purposes of the report.

Thank you, Mr. Chairman.

Mr. Chairman: Oh, out of the corner of my eye, Mr. Pierce, I was going to say that you can wrap up, but I see Dr. Hilliar there.

Dr. Hilliar: Yes, Mr. Chairman, I wanted to add further to Dr. Chevas' comments in that knowing that this committee has to deliberate and make recommendations on this very complex issue, and as you can see from the testimony of the families here as well as the experts in the field and other physicians representing physicians of the province, that this is not a very simple and clear-cut issue.

We do have comments which we've presented here today, but what I would like to do is to have the Committee be mindful of the inefficiencies that sometimes science presents in this cause and effect relationship. And even with the most highly educated population, the most highly educated physician, and the most adhered to reporting system of adverse effects, you are still going to have an adversely-affected child. And I would ask that the Committee be mindful of the fact that these children do require attention and the families require attention.

It is a public health issue, and there should be some public responsibility. And I would ask that some consideration be given to the possibility of looking into the compensation of both the financial and social needs of the children of the families that are affected.

Mr. Chairman: Dr. Pierce?

Mr. Pierce: No, thank you.

Thank you very much, Mr. Chairman. Members of the Committee representing the Ontario Medical Association, I appreciate your taking from your time to come in and providing us with some information with respect to the Bill and also in respect to the amendment.

I guess if I had a disappointment, it would be that you do not have some specific recommendations for amendments or some specific written-out amendments to be applied to the Bill.

I can understand that your efforts have not always been heard by the Ministry of Health in making a better system available to the parents and to the doctors and to the people of the province of Ontario.

But I think that progress is being made however slowly. This is another step in that large step that has to be taken in recognizing that there is a very serious problem there and that certainly compensation is one of the problems that has to be dealt with, whether it be a no-fault compensation program or however it be dealt with. It has to be addressed very shortly, not only in the province of Ontario but across Canada-wide, because it's not only an Ontario problem, it's a community problem.

And I can only hope that by bringing this Bill forward, we get additional recognition from the Ministry of Health and from the federal Ministry responsible for health care in Canada. And that we keep and continue to make strides in advancing and looking after the small children of this province and certainly the parents that all of a sudden, because of that split-second opportunity to protect their child from what could be a crippling disease, are burdened with a disease that's crippling to them as a personal cross to bear within their family.

And I think, certainly, it would do well for every member present here to visit one of families and see what they live with every day. It's a 24 hour job, and it goes on for the rest of their life.

So, I can only say, Mr. Chairman, that I hope that we can make some strides in this Bill and, as I said at the outset, it's not a perfect piece of legislation, but I can only hope we get some recognition for it.

Thank you very much, Mr. Chairman. Thank you, members of the Committee.

Mr. Chairman: As somebody who has been fighting for a better support to people in their homes, special assistance plans from both the past government and the present, I echo that. You should just spend a day with somebody who has to deal with one of these children for the rest of their lives.

But thank you, doctors, and Professor Emeritus Krauser, and we appreciate your coming on such short notice as well.

Sir, I will try and come up with a title for you that is appropriate.

We adjourn until tomorrow morning at 10:00 a.m.

The committee adjourned at 5:23 p.m.

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Public

STANDING COMMITTEE ON SOCIAL DEVELOPMENT
HEALTH PROTECTION AND PROMOTION AMENDMENT ACT
TUESDAY, FEBRUARY 17, 1987
Morning Sitting



STANDING COMMITTEE ON SOCIAL DEVELOPMENT

CHAIRMAN: Johnston, R. F. (Scarborough West NDP)

VICE-CHAIRMAN: Allen, R. (Hamilton West NDP)

Andrewes, P. W. (Lincoln PC)

Baetz, R. C. (Ottawa West PC)

Callahan, R. V. (Brampton L)

Cooke, D. S. (Windsor-Riverside NDP)

Cordiano, J. (Downsview L)

Cousens, W. D. (York Centre PC)

Hart, C. E. (York East L)

Jackson, C. (Burlington South PC)

Reycraft, D. R. (Middlesex L)

Substitutions:

Newman, B. (Windsor-Walkerville L) for Mr. Callahan

Pierce, F. J. (Rainy River PC) for Mr. Cousens

Also taking part:

Hart, C. E., Parliamentary Assistant to the Minister of Health
(York East L)

Clerk: Carrozza, F.

Witnesses:

From the Ministry of Health:

Carlson, Dr. J. A., Senior Medical Consultant, Communicable Disease, Disease
Control and Epidemiology Service

Kendall, Dr. P. R. W., Manager, Disease Control and Epidemiology Service

LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Tuesday, February 17, 1987

The committee met at 10:21 a.m. in room 2.

Bill 52 - An Act to amend the Health Protection
and Promotion Act
(Continued)

The Chairman: Hello, fellow committee members. Legislation Bill 52 presented by Mr. Pierce, an act to amend the Health Protection Act, 1983.

Yesterday we heard from a number of witnesses. Today we will be dealing with it clause-by-clause, but we will start off with questions members might have of the Ministry officials who have joined us.

Maybe you would like to introduce them, Ms. Hart.

Ms. Hart: Yes, I could. On my immediate left Dr. Carlson, Senior Medical Consultant, Communicable Disease. Dr. Carlson started as a paediatrician, and also has been a microbiologist, and so does have a fair bit of background of interest to us today.

Mr. Kendall, Physician Manager, Disease Control and Epidemiology Service.

And I also have with me today Ms. -- from the legal department.

Perhaps we could start with the two questions that Mr. Tetu had yesterday and made a note of. The first one had to do with why pertussis is not made compulsory. Perhaps Ms. Carlson can deal with that.

Dr. Carlson: I think Mr. Tetu asked why it was that pertussis, being a significant disease in infancy and young childhood, was not included in the Immunization of School Pupils Act. The Immunization of School Pupils Act is an act that applies to all children attending school. Pertussis is not a vaccine which is recommended between the age of six...

However, under the Day Nurseries Act, medical officers of health may require immunization as they see fit, and this is tied in with the Health Protection and Promotion Act where there is a guideline that children who are attending day nursery should be immunized against pertussis. So that there is a compulsory component in children attending day nurseries in jurisdictions where medical officers of health

require that.

Ms. Hart: The other question had to do with the technology for a safer vaccine being available twenty years ago. Perhaps you could also deal with that, Dr. Carlson.

Dr. Carlson: I don't know very much about this. The vaccine was a Lily vaccine which was withdrawn at the time when Lily no longer continued to manufacture biologicals, so that we do not have experience of that vaccine. There is, however, now in Canada at Connaught Laboratories, the acellular vaccine, which was discussed at some length yesterday as being used in Japan, and is being studied.

In Ontario we are not able to use vaccines that are not licensed federally. This is done by the Bureau of Biologics, and they require clinical trials which are currently being undertaken by Connaught Laboratories. I don't have a date when they would expect licensure. It would be within the next few years, certainly.

Ms. Hart: Just a follow-up on that. Can I understand from what you are saying that the acellular vaccine is not available for use in Canada as it has not yet been approved?

Dr. Carlson: That's correct, yes.

Ms. Hart: Another area that was mentioned was the combination of the four vaccines in the quad.

Perhaps, Dr. Kendall, you could speak to that?

Dr. Kendall: Yes. The point was made that Ontario in contra-distinction to other Canadian provinces and the U.S. uses a four-component vaccine, DPTP. The fourth component is an inactivated polio vaccine as opposed to the oral polio vaccine which is given separately in other provinces and the U.S. Ontario chose to use the inactivated polio vaccine because it is as effective in preventing polio and it removes the one in five million chance that the live virus vaccine while attenuated could cause paralytic polio in a family member.

Mr. Andrewes: Could you tell me that again?

Mr. Kendall: The oral polio vaccine which is used in other jurisdictions does have approximately a one in five million risk of associated paralytic polio in an unprotected family member who may have never received vaccinating in their life. The inactivated polio which we include in our vaccine removes that risk.

Mr. Andrewes: All right.

Ms. Hart: We have introduced some amendments today, and I will be asking Dr. Carlson and Dr. Kendall to describe

medically why we have used certain wording as opposed to the amendments proposed yesterday, but other than that those were the only questions I made note of.

The Chairman: Further questions for the Ministry people at this stage is possible, as you know, as we go clause-by-clause to ask questions at any time, and for members to get on the list as often as they would like. So it is not something we have to restrict right to the moment, but if you have some right off the top of your heads that you would like before we go into clause-by-clause and before I start talking a little about the procedures that are available to us, why don't we do that.

Mr. Jackson: Mr. Chairman, I believe Dr. Kendall was present at the hearing, at yesterday's session.

Mr. Kendall: That's correct.

Mr. Jackson: That's what I thought.

Dr. Kendall, you were able to hear the presentation by Dr. Gold and Mr. Krauser, and I was wondering if you would respond to some of the comments that they made with respect to their assessments of the current reporting mechanism, and if we could further get a feel from you or from the Ministry, whomever can speak for them, on your degree of satisfaction with the current methodology.

I may want to pursue that in a little more detail.

Ms. Hart: Perhaps I could deal with the last part of your question since I am speaking for the Ministry.

The Ministry is in support of this bill, and in support of the principle of reporting not just the reactions from pertussis but from all vaccines administered to children. So obviously there is some concern about the current system of reporting.

Mr. Jackson: Could you elaborate on the elements of the current reporting system? Was there anything in the presentation by the OMA, elements of that which you are suggesting are elements of concern or required improvement?

Ms. Hart: I am not entirely sure what you are asking me. We are concerned that it is not broad enough, that it is not well used enough, and we are willing to discuss mechanisms in improving it.

Mr. Jackson: Is it within our scope then, Mr. Chairman, I have to ask you if we are to get into that area of tightening basically the three or four questions I raised at the close with respect to reporting, and report writing and entering it into the child's records with respect to... I think you understand the nature of my question.

The Chairman: I would have so see whatever motion was brought forward. One of the procedural matters we will have to decide is what are the limitations to the proposed amendment that has been brought before us, and which has been brought forward on a particular vaccine or on a particular section of the Act which needs to be amended.

Yesterday we received some amendments which were outside of that section, and if there is a question about how broadly one can expand the scope of a piece of legislation then that is before us to deal with. But it seems to me that the question of reporting is dealt with under Bill 52, changing that, to tighten it up or to deal with it would potentially be possible. I would just have to see a motion.

Mr. Jackson: Mr. Chairman, I don't wish to take up time with process, but it is quite, in my two years at the legislature, it is quite unusual to have a bill with this kind of significance without having some comment or presentation from the Ministry that's effected by it, which was a general policy statement, which I guess I received in two sentences from the Parliamentary Assistant. But I guess I am suggesting that there are a lot of related issues with respect to how successful this bill can become and how they affect the workings of the Ministry of Health. I was surprised, quite frankly, that we were not getting a bona fide presentation from the Ministry of Health.

Now, if you are going into it clause-by-clause and deal with it on an ad hoc basis then I will abide by your wish. But I thought something as significant -- it is a short bill but it has a great significance in terms of how it effects the process of immunization in the Province of Ontario.

So I can further be guided by you, Mr. Chairman, but I think it is unusual that we are got getting more of a presentation and an opportunity to delve into those areas before we slip right into clause-by-clause.

The Chairman: Let's be clear about this. It is entirely up to you to take as much time as you would like now in dealing with the Ministry people and getting whatever information you want from them. This is a private member's bill.

Mr. Jackson: Yes.

The Chairman: There is not a lot of precedent for these coming out to committees and--

Mr. Jackson: This is a new day in Ontario, Mr. Chairman.

The Chairman: --when they do come out they could be dealt with in different kinds of ways, and whether or not there is official government statement on a bill or even official government amendments which we are seeing, that are being proposed today, does not necessarily have to be the case. In other situations it has not been, but I am in your hands and so are the Ministry people in terms of how you would like to proceed.

The Parliamentary Assistant would like to comment in response.

Ms. Hart: It is not the habit or the custom in this House to have government presentations on private members' bills. I think you can take from the fact that this Bill had been agreed to come to committee and to be brought with some alacrity that the government is interested in the subject.

We have, this morning, presented amendments that show that we not only agree with the Bill in principle, but we think it should go further. I think that goes a long way towards doing what you request.

In terms of a presentation, you have the Ministry people available to answer your questions.

Mr. Andrewes: Mr. Chairman, I don't quite understand what Ms. Hart is saying. She said that it is not the practice of the Ministry to make a presentation on a private member's Bill, but here we have got some amendments. they're obviously the government's offering to a private member's Bill. So they are prepared to make comment in the form of an amendment, but they are not prepared to make comment in the form of a presentation.

I think what they have got here is a very confusing situation. I guess specifically we have got the OMA having said yesterday, Dr. Chevas, that he has sympathy behind the motivation for Bill 52 but not sure it would be effective. I think we deserve some direction from the Ministry whether or not they are satisfied or dissatisfied with the Bill. Whether the Bill is going in the right direction, whether it is comprehensive enough. I think we need that kind of guidance.

The Chairman: As I say, it is up to you to ask. We have had many opening statements in the past which have never dealt with the matters that members have wanted it to deal with it anyway. And you often find out information you want much more by asking specific questions and asking for that clarification. The floor is now open to members to do that, and to take as long as you would like to do that now in advance of clause-by-clause and during clause-by-clause. I am in your hands.

Is this on the same point of order that we are dealing with it?

Mr. Allen: I suppose you could lump any of my comments under a point of order, Mr. Chairman.

In the first instance, I certainly agree with the comments that have just been made. I suspect the government finds itself a little bit betwixt and between with certain of the impetus that lay within the accord to open up the private members' business and to give it a higher place of status in the affairs of the legislature. So that while in the past it may not have been a practice of responding to private members' bills by way of commentary, if in fact the government is serious in following through that aspect of the Sunshine Reforms, as they were once known, then obviously there is some requirement that they do respond to private members' legislation in a more positive and forthcoming way.

I hear the Parliamentary Assistant saying that when we come to clause-by-clause there will be some discussion from the Ministry about the specific amendments that are proposed. And I appreciate that, but what I wonder is, since, obviously, the amendments come out of a view of the Bill and a view of the issue, whether it would not be proper for the Ministry to provide us with that larger frame of reference out of which they arise in the first instance so that we can understand the extent of concern and the range of possibility that the Ministry sees in addressing this issue.

As I glance at them they certainly are supportable additions. So it would seem at first glance, without committing myself in detail until I have a chance to look at them more carefully.

Since it also determines a little bit on procedures as to how much we try to include in our discussion of this Bill in the range of our attempts to amend it, I am concerned also with what we learned yesterday to the effect that the Ontario system of reporting has apparently been much, much less satisfactory than that of British Columbia, that of Alberta, that of Saskatchewan, and I wonder if the Ministry has got any further observations about why that has been so.

I note in an article that we were circulated yesterday that the indication appears to be that those three provinces have: "...very highly organized systems of giving vaccines through public health clinics, and therefore do a much better job of reporting adverse reactions."

One begins to wonder then whether in some respect this committee should be also dealing with the structure and

system of delivering inoculation and vaccination in the province, if that so materially affects the capacity to report adverse reactions. So that whether that gets embodied in the Bill or whether it becomes embodied in a recommendation from this committee to the Ministry, another point at issue in that respect would be the question of a large scale public education campaign around the whole issue. Is that something that can be embodied in the Bill and made a requirement of the Ministry, or is that something that this committee should address in another fashion, namely, by recommendation to the Ministry itself in the strongest possible terms. Those, I think, Mr. Chairman, are also points of order in terms of how we proceed and the scale in which we view our amending and discussion process of this piece of legislation. So I would like to lay that on.

But specifically to ask the Parliamentary Assistant if she or the officials present would care to comment upon the relationship of the delivery system in this province as against some other provinces, and whether there are some inherent impediments in our system as against alternatives such as the Public Health delivery systems for vaccination processes.

The Chairman: Let's do one point of order at a time. Is this a point of order?

Mr. Cordiano: It seems to me we are asking questions at this point. I thought we were on the point of order and I was going to address the point of order, but if you want to move on and ask the Ministry officials specific questions, which I think my colleague was asking, we could certainly do that and I have no problem with that.

The Chairman: My point is, it was only that we started off with questions, and I was in complaint that there is no opening statement, but there is no opening statement. We could proceed--

Mr. Cordiano: So let's proceed.

The Chairman: --with the questions and then just figure we are going to jump off a list here. Might I suggest that we do Mr. Allen's question, go back to Mr. Jackson and the list then for further questions, unless you want to adjourn for the rest of the day and wait until the Ministry comes up with an opening statement and then come back some other time.

Ms. Hart: The question has just been asked; can I respond to it?

The Chairman: Is it my understanding that we are moving ahead?

Mr. Cordiano: That's fine. You can proceed, Mr. Chairman--

The Chairman: Mr. Allen then, please.

Ms. Hart: Mr. Allen, you make the assumption that the reporting, perhaps if I might call it under-reporting, in Ontario, is a result of the delivery mechanism for the vaccines. I might point out to you that our reporting system particularly for young children is not mandatory, it is a voluntary system, and it would seem to me that that would have a much greater impact, at least initially, on reporting than the delivery mechanism.

We haven't heard any evidence, for example, that there is anything wrong with the way we give vaccines; it is just the question of requiring doctors to report reactions. We have not done that.

Mr. Allen: Madam Parliamentary Assistant, I would like to hear from Ministry specialists in that regard.

No, it's true, that didn't become a central focus of discussion yesterday afternoon, and I wouldn't have expected the OMA to tell us that they don't deliver it well.

The parents at least left us some questions, I think hanging, as a result of their experience with doctors in private practice providing the main delivery system for vaccination, and all that I am observing is that there is some evidence that a different kind of delivery system in British Columbia, and Saskatchewan and Alberta seems to be much, much more effective. Is that because there is legislative, that it is mandated legislatively? Is it because of the structure of the delivery system? Is it the ethos of public health in British Columbia as against Ontario? I don't know. I mean I am not a specialist.

Those are questions I think are very important for us to be able to grapple with in deciding what kind of mechanism is most satisfactory for securing the most efficient reporting of adverse reaction. That's all.

Ms. Hart: What you say may very well be true, but it seems to me that what this act deal with is the reporting mechanism, not the delivery of vaccines. And we haven't gone through public hearings saying to people we are looking at that; that may be the next step. But it seems to me under this act that goes far beyond what we are here to discuss.

Mr. Allen: That's why, of course, I raise those as a point of order in terms of procedures, as to whether we can tackle this questions as a committee through the Bill or

whether we do it through some other vehicle at this point in time. But because of the significance of the issue, it seems to me that it would be useful to have the Ministry staff who have some experience in the area tell us what their sense is of where we stand in our delivery system, vis-a-vis other provincial delivery systems, and what the significant differences are and whether they are matters that we can legitimately consider in terms of this Bill.

Ms. Hart: Mr. Kendall, have you studied that, a comparison--

The Chairman: First of all, I will just deal with a point of order on it and that is that it is perfectly in order to discuss this and have this kind of conversation and back it up as to what we are doing.

We have a very restricted Bill before us, and to talk about moving towards a public health administered vaccine program for pre-school kids would be outside of the context of the Bill as has been presented to us; and, therefore, if the committee wished to make a statement about that the Minister would have to find other methods of doing that. For instance, a letter from me, as the Chair, after a motion to the Minister saying that we want you to do such and such; but it would not be something that could be dealt with in an amendment to Mr. Pierce's Bill, as I see it.

Mr. Allen: If that is a ruling, Mr. Chair, I will accept that, but I will also perhaps give notice that we will be introducing such a document for the committee to consider.

The Chairman: Sure. In fact, I didn't want to curtail the response, because the whole question obviously of delivery systems and reporting are interconnected. And one of the problems we have here of Dr. Day's (phon.) system is a problem in reporting at this stage.

Ms. Hart: I think I got a negative answer, didn't I?

Mr. Kendall: We haven't specifically studied it.

Mr. Cooke: Do you have any opinion?

Ms. Hart: That is hardly fair to civil servants when they haven't studied it.

Mr. Cooke: Ms. Hart, maybe you haven't done much clause-by-clause, but there are a lot of things that we ask civil servants for under opinion. We are not asking for a policy, we are asking for an opinion as a professional.

The Chairman: Go ahead.

Dr. Kendall: We estimate that some 750,000 doses of DPTP are supplied annually by the Ministry to the 15,000 physicians in the province. To draw the inference from the persons we heard yesterday that all physicians in the province fail to inform their patients, I think would be a large inference to draw from the slender evidentiary base.

Mr. Baetz: Would be what?

Dr. Kendall: It would be a large inference to draw from the small evidentiary base.

Mr. Baetz: A large inference. Too large is what you are saying.

The Chairman: Mr. Andrewes, on this point?

Mr. Andrewes: We recognize the inference that was made. Doctor, I guess my concern is that we had the Ontario Medical Association representatives here saying that they certainly weren't suggesting that the delivery mechanism was faulty. What they were suggesting is that the reporting mechanism could not be effective, as effective as it is in other provinces given the mechanism that we currently have in place.

Mr. Cooke's question was more specific, and that was relative to the reporting mechanism, would it in fact be enhanced if we followed the system that is currently in place in Alberta?

Dr. Carlson: I would like to answer that by saying that in looking at this you have to weigh the pros and cons of any system. I think if we look at the numbers of 16,000, 15,000 physicians in Ontario versus however many health units they have in Alberta, which is many fewer, you would obviously say that you have to get many fewer people to report; therefore, the odds of getting reports is higher. That's all I can say.

The Chairman: Now to go back to the list. Mr. Jackson, you were raising some questions when we--

Mr. Jackson: Unfortunately Ms. Hart had to leave yesterday before I completely my series of questions which I alluded to at the very close, it was about 5:20 yesterday.

It occurred to me that given the radical readjustment of the medical delivery system in this province, that we are faced now with the situation of all those items not covered by OHIP being charged directly to patients in many instances. And the question I raised for wishing a Ministry response was: To the extent to which this Bill or the improved and required, essentially, monitoring reporting and reporting mechanism, to what extent will that be covered

under OHIP, and to what extent has the Minister authorized that that would be covered.

That question is of concern because I want to know if I am setting in motion more items to be put on the already full plate of persons who are paying for fees that are not covered by OHIP. And it certainly is not going to break me for Amy's next booster, but it would be a matter of concern for a lot of families in Ontario. I think the medical profession would want answers to that question as well.

Ms. Hart: As I understand it, the giving of the vaccine is covered by OHIP, and the OMA and the Ministry are currently in negotiation about exactly what is covered by each medical procedure in the OHIP schedule. I think that it is fair to say that the whole procedure is intended to be covered, but I can't give you a specific answer until the conclusion of those negotiations.

Mr. Jackson: Let me ask it another way. Currently it is voluntary, and therefore currently it is not covered. Obviously the injection and the visit requiring the injection as a result of the injection are covered. But I asked several questions of the physicians with respect to my telephoning the doctor the following day to advise him or her that my daughter has had an adverse reaction to her booster, and there was no clear consensus that they were able to charge at all for that through OHIP, but that they were able to charge me for that.

Then there was a certain point raised about mandatory reporting and records keeping of that which was a second concern raised. And then the third concern was the parent access to that record which was the doctor's recorded comments of the conversation.

You have to realize the doctor is not examining the child. The doctor is only putting into the report what the mother or the father told the doctor. And of course as you recall from the Bill 94, that was a serious matter because the doctor could say the parent seems to be reacting with a degree of hysteria. There is some concern, and this is a matter for your Attorney General, I would imagine, with respect to whether or not a parent should see be able to see what the doctor wrote about his opinion about the mother's attitude about the child's reaction to the vaccine.

These were matters that I raised yesterday, which I feel should be covered and cleared by the Ministry before we set in motion or impose across the province something we all support, but is going to set in motion another reaction out there. I think we should get a clear and definitive statement from the Minister that the public is not going to be asked to have to pay to do its monitoring out of its own pocket to measure a reaction to a vaccine. And in no way do

I wish that because I believe it to be a major deterrent, because my colleagues in the NDP are very fond of reminding me that if a person in Ontario has to pay anything out their pocket for medical attention it becomes in some way a deterrent. I listened to four and a half months of that.

Mr. Cooke: Does that mean we have convinced you?

Mr. Jackson: No. I am just saying I know you would be quick to remind me of that, and so I thought I would raise the point in advance of that. I think it is an important enough point that we cannot leave it to negotiations, that we should get a clear statement from the Minister that those will be an understanding by the Ministry that this procedure being regulated will be covered.

The Chairman: I think it is fair to ask the question, and it is also something we couldn't place in the Bill. But it is fair to raise the question.

Mr. Jackson: But if the government is committed, Mr. Chairman, to making this work then they shouldn't have any difficulty in making a clear, unequivocal statement. I mean it isn't the first time in negotiations which all of us have done in a variety of public forums to make amendments. We have done it with the teachers of this province where we have made adjustments -- during the course of legislation we have made amendments, provincial amendments to superannuation. It is not uncommon for the Minister, in the context of negotiations on a sensitive issue, to state that these following procedures I automatically agree would be included, because we have now created a law in this province saying that they will be regulated and monitored.

The Chairman: Just to be clear. What we did on the superannuation question was to send a letter to the Treasurer and to the Ministry of Education recommending that there be a window of opportunity for early retirement, and they then negotiated with the teachers to come up with that.

What we have now is a similar situation, a good parallel actually, in the sense you have negotiations of what should be covered by OHIP and what shouldn't be covered by OHIP. And again it would be possible for a committee to express its opinion on that and to send that to the Minister with whatever results; maybe as positive as we got with superannuation or with none. But it would be outside the parameters of this Bill because we are talking about a very different process and a different piece of legislation that covers OHIP premiums and what they cover.

Mr. Cooke: Maybe someone can just clarify for me. What is covered now and what isn't covered? I haven't come across vaccines being a problem when they are given in a

doctor's office.

The Chairman: A vaccine given in the doctor's office is covered, as we learned yesterday. What may not be covered is when the parent is worried about an adverse reaction and phones the doctor for advice about it. The telephone consultation may or may not be -- it is presumed it is not covered under OHIP actually, according to the OMA people yesterday.

So the question then is respecting reporting, whether or not the fact that that is not covered and that there is no systematic reporting necessary - although we were told of some guidelines that are presented to doctors for that is the appropriate recording that we would want, that then gets into whatever registry we established, that it takes place.

Mr. Cooke: If there is a reaction and an emergency appointment is made with the doctor or the child is attended at the emergency department of a hospital as a result of a reaction, then obviously there is no problem. What we are really talking about is this wide discussion of whether OHIP should cover telephone advice. With all due respect to Mr. Jackson, I assume it would be very difficult to say that the only telephone advice that would be covered by OHIP would be that of an adverse reaction under Bill 52. I mean if you are going to cover telephone advice I guess you have to cover all telephone advice.

Mr. Jackson: Not necessarily, Mr. Chairman. What we are trying to establish is what are we going to do, what are we going to set the rules of the procedures for all reporting and monitoring, because monitoring is as important as reporting, the situation immediately following the injection. And it would be very simple to state that it is a billable expense if there is a consultation required by phone or by visit or by whatever for the parent and the child, and/or the child.

That I don't think means that every time you pick up the phone the doctor can Bill OHIP. I think it is stating that if there is a procedure that may require telephone contact then that will be covered.

The Chairman: Mr. Pierce?

Mr. Pierce: I think also the point that was being brought up yesterday was whether in fact on a phone call to the doctor, and not only on a phone call for advice, but on a phone call to alerting the doctor that there has been a reaction, and requesting that the doctor enter it into his records of the child, and whether the charge would be up acceptable to OHIP when the doctor closed the file and in fact makes that registration.

Mr. Cooke: I apologize for not being here yesterday,

but one of the reasons I would assume for reporting would be because we want to, first of all, try to prevent any further reaction, but also to keep statistical information as to what is happening. Would there not be a concern from the professionals if their reporting mechanism was by observation of the parents and then recorded by telephone without the doctor observing the child or examining the child; would there be a concern that the statistics that are being kept might in fact be inaccurate?

Dr. Carlson: It would be appropriate to have a physician examine a child in any serious incident occurring after a vaccine, certainly. There might be some minor incidents that would be described, such as redness, local reactions which might be not necessarily seen by the physicians.

Mr. Cooke: But any of the reactions that you are suggesting should be reported under your amendments are sufficient enough that a doctor should examine the child?

The Chairman: Mr. Cordiano, would you like to--

Mr. Cordiano: I think this question of telephone conversation being covered by OHIP, that brings up a larger issue which I don't think really affects the intent of the Bill. The fact that a doctor might be reluctant to record a telephone conversation, well, I think if the reaction to the vaccine is serious enough then obviously a visit has to be made to the doctor's office or hospitalization has to take place for that child. And I think that seemingly is enough of a factor for the doctor to record the information and not have it simply recorded as a result of a telephone conversation. So I don't think that's a real issue to this Bill.

The fact that there is a lack of incentive there for doctors, which may or may not be the case. I don't see it as being the case, but you may want to argue that point.

Mr. Jackson: You missed my point. My point is, I don't want it to appear in any form as a deterrent to the parent. As you recall from yesterday we are talking about a comprehensive public education. Well, that is doctors, but it is also for parents to alert them to the danger signs.

Now we have got the danger signs, and they believe that there may or may not be an adverse reaction. But some people may say, well, now as soon as I pick up the phone that is going to be another part of my hundred dollars a year which I have to pay the physician for all those, you know, the check list; or it is going to cost me the \$6.00 per call which is generally -- I think it is \$7.50 now a call, the average they are running it at.

This was the point. I don't want to deviate too far from that. There is where the deterrent is, not in the medical profession. The issue of substance there is the one of whether or not they can provide the records to the parent if they record that: I think Mrs. so and so was acting hysterical about her daughter. That was another issue which I didn't want to get into today, but that was the concern point that I had for physicians.

Mr. Cordiano: I think that is a separate issue which has to be resolved in another forum, if you will. But certainly I don't think it is a disincentive to parents, because they will be quite concerned about the reaction that is taking place to the child. So I don't think that is a disincentive to parents. I think if they have to go and pick up the phone and speak to the doctor, I don't see any disincentive there.

Mr. Jackson: Mr. Chairman, my other question was with respect to: Is there a provincial compensation plan currently under review or are there plans to review, to develop a compensation plan?

Ms. Hart: The first week in February there was a conference of Deputy Ministers of Health across Canada, and that was on the agenda and it is currently being discussed.

Mr. Cooke: This is a nationwide plan with the Federal Government?

Ms. Hart: Yes.

Mr. Jackson: So my understanding is you are not currently examining a plan similar to the Quebec compensation plan?

Ms. Hart: I can't tell you the details of what is being discussed. I can say that it is under review.

Mr. Jackson: So you are not examining the Quebec plan, you are looking at a national plan?

Ms. Hart: Yes.

Mr. Jackson: Okay.

Ms. Hart: I mean I can't say we are not examining the Quebec plan, but I can say that we are looking at a national plan. Whether or not they are adapting the Quebec plan--

Mr. Jackson: No. I meant a separate plan.

Ms. Hart: --in the national forum, I don't know.

Mr. Jackson: No. I am saying a separate plan for

Ontario built in Ontario for Ontario. You are saying you would rather just wait for the federal government to develop a national plan. That's the thrust of which I am hearing from the Ministry.

Ms. Hart: No. What I said to you was that the Provincial Deputy Ministers met and are considering a plan that will apply across Canada. Whether or not that will be in the form of a federal piece of legislation or individual pieces of legislation in each province, I can't tell you. I suspect the latter, but I don't know. But it is an initiative across the country.

Mr. Pierce: If I can just follow-up on that. As I understand what you are saying, is that the provincial government at this point in time is not looking at a compensation program, a no-fault compensation program within the Province of Ontario.

Ms. Hart: No.

Mr. Pierce: They are participating in discussions at the federal level.

Ms. Hart: What I said to you or I said to Mr. Jackson is, yes, indeed we are considering a compensation program in conjunction with the other provinces. That doesn't make it any less a compensation program in Ontario.

Mr. Pierce: All right.

The Chairman: I have you next on the list, Mr. Pierce.

Mr. Pierce: A question to Dr. Carlson and Dr. Kendall. At yesterday's sessions there were circulated copies of proposed amendments as were being proposed by the Association of Vaccine Damaged Children, and this morning we received counter-amendments from the Ministry of Health. I guess the question I would have is: Have the amendments been drafted since the presentation of the other amendments from the Association for Vaccine Damaged Children or were the amendments drafted prior to the session yesterday?

Ms. Hart: Perhaps I can deal with that. They were partially drafted before yesterday, and they were amended since yesterday.

Mr. Pierce: They were amended in which direction?

Ms. Hart: Broader.

Mr. Pierce: Broader?

Ms. Hart: Yes.

Mr. Pierce: As a result of the proposed amendments by the association?

Ms. Hart: Yes.

Mr. Pierce: Can I ask you then to go further on a broad scope, what the difference is between the amendments as proposed by the association and the amendments as proposed by the Ministry?

Ms. Hart: We can do that. We were intending to do it as we went through it clause-by-clause.

The Chairman: That would be more appropriate actually if you want to.

Mr. Pierce: All right.

The Chairman: What will happen on the process, Mr. Pierce, is that the government amendments be placed first, and as we go through the government amendments discussion of them as opposed to other amendments would be appropriate.

This might be the best time to talk about more generalized issues as has been raised that may or may not not fit within the parameters of this point. You might find it more useful doing it with regard-- since we don't have this--

Mr. Cordiano, you were on the list.

Mr. Cordiano: That's fine.

The Chairman: Mr. Baetz?

Mr. Baetz: Yes. Mr. Chairman, I just want to record my own concern about the approach of the Ministry on this legislation, and it is seemingly reluctance to comment in a more comprehensive manner, especially because of what we heard yesterday. We really heard two groups, the parents of the victims and the doctors, discussing the same problem but it was very obvious in their presentations that their perceptions of this same problem were totally or substantially different, quite different.

The parents had a perception of the problem and its severity, and also there seemed to be questions about the incidence, how wide spread is this. The parents certainly seemed to have left the impression it is more wide spread than, say, the doctors did. There were very different points of view on how to deal with the problem. Doctors saying, well, you know, it is a very, very complex thing, it isn't as simple as the parents may feel it to be; and, therefore, it is more difficult to deal with it then the parents were suggesting or that perhaps any kind of

legislation would suggest. So we had really yesterday a substantial gap, I thought, in perceptions of the problem and how to deal with it.

I would have hoped, therefore, particularly, that the Ministry acting as sort of a jury over this thing or referee, being impartial, thinking only of the public good, would have come this morning with a rather broad and comprehensive statement giving your perception of what you think the problem is and how you think we can deal with it. And especially I think, the Parliamentary Assistant said, well, you know, this is a private member's Bill, therefore the Ministry isn't expected to make this rather comprehensive statement about it. But I could argue that precisely because it is a private member's Bill, the Ministry ought to be saying more about it, especially since they are supporting it and they are introducing an amendment to it.

I guess really, Mr. Chairman, I am a little concerned about, how should one say it, the cute way in which the Ministry is approaching this whole subject. We had one very short statement here by one of the professionals in the Ministry which I found very useful. I have an idea that if they were prepared to talk about this subject in a more general way we would, as a committee, and perhaps the general public, and certainly maybe the parents, would have a far better and a more precise understanding of what this problem really is.

I can understand the doctors on one hand saying, look, it is a little more difficult to diagnose what has happened in this case than maybe a parent thinks it is. But really I think, Mr. Chairman, that I must say I feel a little frustrated at the stance of the Ministry.

And then, of course, I am going to get into the--

Mr. Cooke: It is frustrating being in opposition, though.

Mr. Baetz: Pardon?

Mr. Cooke: It is frustrating being in opposition, you are just learning.

Mr. Baetz: Under any circumstances I would think that this is one time where the Ministry could be very forthright without getting into big policy issues, and so on.

The other thing, and we will get into this in more detail, but as Mr. Pierce pointed out the amendment introduced by the Minister this morning or about to be introduced differs from that introduced by the parents yesterday. I can appreciate that, there is no problem

there. .

But one of the fundamentals in there, I notice that the amendments by the parents yesterday says when you talk about reporting you ought to also be reporting to the parents. There is nothing about reporting to the parents in the amendment introduced by the Minister, unless I missed the line. So right off the bat, you know, I think we are too much in a fog and too much in the dark here.

Mr. Reycraft: Some of us are.

Mr. Baetz: Anyway, that's it.

Thank you very much.

The Chairman: Would you like to respond?

Ms. Hart: No. I think I have already responded.

The Chairman: Mr. Andrewes?

Mr. Baetz: I shall continue in my state of frustration then.

Mr. Andrewes: If I can add to Mr. Baetz' state of frustration. Simply to point out, Mr. Chairman, I don't think I need to in this committee, this is a private member's Bill. Once we do, if we eventually get to clause-by-clause, which I assume we will--

The Chairman: I am beginning to have my doubts.

Mr. Andrewes: --at some point in time. It will be reported back to the legislature likely as amended and will become law.

What I am hearing, I think, from those that will be administering the law is that the reporting mechanism is not as comprehensive as it is in other provinces, but the mechanisms suggested in the Bill are better than nothing; they may need further legislative amendments which might include a different delivery mechanism or compensation or perhaps some other activity.

But perhaps Mr. Baetz' frustration is shared by a number of us who are faced with the task in this committee to try and produce a good Bill and an effective law without the benefit of the guidance of those who are going to be administering this law.

The Chairman: Mr. Cooke?

Mr. Cooke: Mr. Chairman, it seems to me we have two options; we can go ahead with clause-by-clause now, or if

the committee is not satisfied with the response of the Ministry we can pass a motion requesting a total response and schedule the clause-by-clause for a date when the House comes back. Let's do one or the other.

Mr. Baetz: Mr. Chairman, I certainly think we should, if I may, I think we should proceed clause-by-clause. I mean, even though I am frustrated, and maybe we will even elicit a little bit of information as we go along from the experts who are here.

The Chairman: It may be the means of overcoming your frustration.

Mr. Baetz: Yes.

The Chairman: Mr. Jackson?

Mr. Jackson: Mr. Chairman, I would like to ask Dr. Carlson, if I might. We heard some deputations yesterday with respect to the varying initial date for inoculations that may vary across Canada, and indeed within the province. We heard two months, three months, six months.

Could you comment on what is recommended for Ontario and why, and is this matter under review?

Dr. Carlson: Ontario recommends the immunization schedule which is currently the one recommended by the National Advisory Committee on immunization in which diphtheria, tetanus, polio and pertussis vaccine is initiated at two months. Given at two, four, six months and again at eighteen months for the booster pre-school; and measles, mumps, rubella given after the first birthday, as soon as possible after the first birthday.

Mr. Jackson: Are there any jurisdictions in Canada that are not adhering to the two months date?

Dr. Carlson: I believe they all are, although some may give it nearer three months for the first injection. But there is no wider difference than that. There are not any using the six months initiation.

Mr. Jackson: Dr. Kendall, could you advise as to what the current cost is for the vaccine. As I understand it, there has been a rather major increase in the cost of the vaccine to the government because of some compensation requirements of the manufacturer.

I could ask Dr. Carlson as well, so whoever.

Dr. Kendall: It is currently around \$8.00 per dose. This represents a recent increase of \$3.00 per dose that was put on my Connaught on their pertussis component.

The Chairman: They have a monopoly, as I understand it, Doctor.

Mr. Jackson: To your knowledge, is the drug being distributed in similar form or fashion in the United States by that manufacturer, or is Ontario a major market, an exclusive market?

Dr. Carlson: I believe Nova Scotia and Newfoundland use the DPTP polio with the inactivated polio component. I am not aware of any jurisdiction in the United States that uses this for infant immunization. They do recommend inactivated polio for adults who require it.

Mr. Jackson: So then what would they be using in Quebec, for example?

Dr. Carlson: In Quebec they use all polio vaccine.

Dr. Kendall: Coupled with diphtheria, pertussis and tetanus which is a triple vaccine.

Mr. Jackson: The same manufacturer?

Dr. Carlson: The manufacturer is now Connaught. It is sold through the institute Armand Frapier but I believe it is all manufactured as Dr. Gold said yesterday by Connaught Laboratories.

Mr. Jackson: They seem to be the only one specializing in biological prescriptions?

Dr. Carlson: The institute Armand Frapier do make some of the components.

Mr. Pierce: Just to supplement that, Mr. Chairman, my understanding is that Connaught does not distribute the drug manufacturing in Canada through the U. S. because of all the pending lawsuits in the U.S.

Dr. Carlson: I can't answer that. There is Connaught Laboratories Incorporated in the United States and they do distribute diphtheria, pertussis, tetanus vaccines. I can't answer the details of what is manufactured where.

Mr. Jackson: Does the government in any department or in any way measure what has been referred to as bad lots or the existence of bad lots of vaccine when they appear in the Ontario market?

Dr. Carlson: The government of Ontario, are you referring to?

Mr. Jackson: Well, and--

Dr. Carlson: And the federal government. Each lot of vaccine is released by the Bureau of Biologics in Ottawa. So that for a lot to be released, it must reach certain standards. If there were evidence that a lot were failing to comply once it was out in the field there would be a recall.

Mr. Jackson: Then to what extent has the incidence of recall occurred in Ontario with respect to this vaccine?

Dr. Carlson: DPT?

Mr. Jackson: Yes.

Dr. Carlson: The only recall that we have had in recent years was related to a polio component vaccine where one of the types of polio, type 2, was found to be less effective.

Mr. Jackson: Can I ask you then: Is it possible then to be able to determine with a broad enough base of data, the existence of a bad lot under the current reporting mechanism?

Dr. Carlson: A reporting mechanism I think is in place in Ontario and is as comprehensive as in other provinces. We have a dual reporting system. We have a system whereby medical officers of health can report to the Ministry on a form which we provide regarding any reaction to vaccines which may have occurred which may come to their attention, and the physician can report to the medical officer of health.

There is also a reporting system through the Ontario Medical Association, which you heard about yesterday. These reports are shared. We share the reports with the OMA, so that we are all aware of them. So that the reporting system is there. And if there is evidence that a lot of vaccine were causing more problems immediately, the reporting system is there for those to be reported.

Mr. Cooke: The adverse reaction reporting system through the OMA, is that that is the same one as for prescriptions, I take it?

Dr. Carlson: Yes.

Mr. Cooke: I mean there was certainly evidence when we were dealing with Bills 54 and 55. In one case it was raised in the legislation that the OMA became aware of an adverse reaction several months before it was reported to the Drug and Therapeutic Committee of the Ministry of Health. So that if there was a bad lot it could in fact, if it takes that long for it to get out of the bureaucracy of

the OMA and into the bureaucracy of the Ministry of Health, it wouldn't be terribly effective.

Dr. Carlson: I think if it were reported to us in the Disease Control and Epidemiology Service--

Mr. Cooke: If the problem was that it didn't get out of the OMA for six months.

Dr. Carlson: We would receive it and act on it in addition, you know. It is necessary to have the lot of vaccine to determine where--

Mr. Jackson: That's why I prefaced my comment by the fact that you would have to have a reasonably large data base in order to feel that you have a case. I mean you are getting cases of adverse reactions which would be indigenous to the child's biochemistry and not necessarily any flaw in the vaccine.

Is that not a basic administrative response that if the child is having an adverse reaction it is because of -- not necessarily because of the bad batch, but because of the child's physiology?

Dr. Carlson: I don't think so. I think that each of the reactions that is reported in Ontario, I see when they come pass by desk, if there is a concern there is a concern there is a cluster of significant reactions I can certainly do something. And I report that to Connaught Laboratories that there is a number of reactions involving a certain lot. I think the mechanism is there.

Mr. Jackson: You have not had to report to Connaught about adverse reactions?

Dr. Carlson: I report to Connaught on all our adverse reactions. Giving the lot number, if I have it, and the initials; I don't give any personal identifiers.

Mr. Jackson: Very well. So you are reporting the adverse reactions?

Dr. Carlson: To Connaught.

Mr. Jackson: How then can we have access to those reports if they are non-identifying?

Dr. Carlson: In terms of the individual?

Mr. Jackson: Over a given period there were x number of reported cases, whether or not they were based on, whether or not you felt it was a problem with the serum, the vaccine, or whether it was the child's physiology?

I mean, are you just reporting adverse reactions to a company, or are you measuring for the purposes of a bad lot, or are you measuring for the purposes of not proceeding with the second or third booster by virtue of the child's reaction to what may be a very safe vaccine, a pure vaccine?

Dr. Carlson: In fact, all those things are being done. The reports go to Connaught; the lot numbers, if they are available, are sent to Connaught and they will monitor and certainly they are very aware if there is a significant number of reactions that come in related to a particular lot. If a child receives a dose of DPT polio and is reported to me with a reaction which I would consider a contra-indication to further vaccines, either with pertussis or all of it, I write back to the individual who has reported and indicate that.

Mr. Jackson: If this case it will be the physician?

Dr. Carlson: It is usually the medical officer of health who reports to me. I am unable to do that with the reports to the OMA because I have no identifier.

Mr. Jackson: My last question on that point, Mr. Chairman, is: Are we able to get the statistics of reported cases to the sole manufacturer of the supplier of the drug for the children of Ontario?

Ms. Hart: Over what period? Can you be a little more specific?

The Chairman: When do you want it?

Mr. Jackson: I don't need it by 11:30 today, Mr. Chairman.

The Chairman: That is when we were supposedly completing this.

Mr. Jackson: No. Well, that's fair ball. But it is clear that there may be a minority report as a function of this Bill; it may be debated in the House, and unless there is rules for private member's Bill that are not too dissimilar from the rules of the regular government Bill, then that is a perfectly reasonable request. And I would like that data base for a reasonable numbers of years, but you could always advise me of the number of years that you have the data. In these cases, generally, we find out you have only been recording them since a certain point.

The Chairman: A couple of things. One, there is no such thing as a minority report on a piece of legislation.

Mr. Jackson: That's part of the debate in the House, I guess, Mr. Chairman.

The Chairman: It might be a division of votes maybe, but not a minority--

Can you tell me what sort of time period we might be able to get that kind of information for?

Ms. Hart: We have some of that information now, as I understand it. We do not have access to the -- it is not that we don't have access -- we cannot give the numbers of reports to the OMA because of our agreement with the OMA.

The Chairman: Why don't you describe what you have for us and take us through it.

Dr. Carlson: What I did was I looked up the reported reactions to DPT polio during 1986 that we have, and I have records of 54 reports. Of those 38 were fever of which only two were over 40 degrees; 24 of the reports were screaming and crying greater than three hours, although there were some that were less than three hours; five were reports of convulsions or possible convulsions; and one was a report of encephalitis; there were six reports of drowsiness.

The Chairman: We heard from the OMA yesterday that there were 86 or 87, something like that, reports last year.

Dr. Carlson: For all vaccines. This is just a single vaccine.

The Chairman: That's right.

Mr. Reycraft: --reports of which they deemed 87 to be serious.

The Chairman: That's right. Thank you.

That was for all the vaccines?

Mr. Reycraft: Yes.

Mr. Jackson: Thank you, Mr. Chairman.

The Chairman: You are welcome, Mr. Jackson.

Are the members ready to proceed with clause-by-clause? There are not many of sections obviously of the Bill; we will proceed with 37(a), taking government amendments first, and then during that period you can discuss the relative merits of that amendment versus others which you are aware of, for instance, that were distributed yesterday or that you may have in mind to present as members of one of the opposition caucuses. And that might serve, because that is the key subsection, that might serve to be the nub of debate, if I can put it that way. And we can go

through it. I think the best thing would be to present the government motion in its entirety, and then if members wish to break that down for votes as we go through it in subsections, that would be the easiest way to proceed.

If there are other matters the committee wishes to deal with that are not going to be dealt with within the actual subsections of this act, then we would reserve those for motions following the conclusion of the clause-by-clause of the actual Bill. And then, for instance, if there are directions you would like me to send to the Ministry of Health then I would be open for those kind of motions at that time, but not until we get to that stage.

So we are dealing with the government motion first. I just have a slight rewording, but I am sure that will be spelled out. I should indicate that as the matters come to votes here, that the Parliamentary Assistant is a member of the committee and does have a vote with the Liberal caucus of the committee. Sometimes when we get to that stage the tradition is for you to go back and take your seat over there, but I have been able to count hands on either side of me, so it doesn't really matter to me. If other members feel perturbed about that, then we will ask her to take her seat, otherwise we will just proceed along.

So I will read what we have, which is:

"Agreed to by her Majesty by and with the advice and consent of the Legislative Assembly of the Province of Ontario enacts as follows:

(1) The Health Protection and Promotion Act 1983, being chapter 10, is amended by adding thereto the following section,"

And we have a proposed government amendment to section 37(a).

Mr. Cordiano?

Mr. Cordiano: I move that section (1) of the Bill be renumbered as section 1(a) and that the following section be added thereto:

(1) Section 31 of the Health Protection and Promotion Act, being chapter 10, as amended by adding after diseases in the second line, "unreportable events".

I move that section 37(a) of the Act as set out in section 1 of the Bill be struck out and the following substituted therefore:

37(a)(1) in this section (a) "reportable event" means,
(i) persistent crying or screaming--

The Chairman: Let me just clarify what is happening here, because we are getting a little confusing. The first motion that Mr. Cordiano is moving is for subsection (1),

that which I have just read. There really is no point in moving that until we have dealt with the longer piece. So what I would suggest you do is move the one that is typed, the one the members had before them first, change wording on the introduction.

So if we leave that, first we will go back as that carries to the section (1) again, and we will re-enter the one other.

Mr. Cordiano: I move that section 37(a) of the Act as set out in section (1) of the Bill be struck out and the following substituted, therefore:

37(a)(1) and this section (a) "reportable event" means,

- (i) persistent crying or screaming, anaphylaxis or anaphylactic shock occurring within twenty-four hours after the administration of an immunizing agent;
- (ii) shock-like collapse, high fever or convulsions occurring within three days after the administration of an immunization agent; or,
- (iii) generalized urticaria, encephalopathy, encephalitis or any other significant occurrence occurring within fifteen days after the administration of an immunization agent;
- (iv) arthritis;

And then (b) "immunizing agent" means a vaccine or combination of vaccines--

The Chairman: So there are four.

Mr. Cordiano: Four is arthritis.

The Chairman: Four should be arthritis.

Mr. Cordiano: An addition there.

I will start with (b) again:

(b) "Immunizing agent" means a vaccine or combination of vaccines administered for immunization against diphtheria, tetanus, poliomyelitis, pertussis, measles, rubella, hepatitis B, rabies, haemophilus, influenza, B infections, influenza or prescribed disease.

That is a mouth full. I will stop there, Mr. Chairman.

The Chairman: No. I would like, if you would, read the next two sections. They are a little hard to understand.

Mr. Cordiano: I am a little confused as to whether I

should move on through the whole thing.

The Chairman: I would like you to do sub (2) and sub (3).

Mr. Cordiano: Okay. Fine.

(2) A physician or person registered under Part IV (nursing) or Part VI (pharmacy) of the Health Disciplines Act who, while providing professional services to a person, recognizes the presence of a reportable event and forms the opinion that it may be related to the administration of an immunizing agent shall, within seven days after recognizing the reportable event, report thereon to the medical officer of health, of the health unit where the professional services are provided.

(3) A medical officer of health who receives a report under subsection (2) concerning a person who resides in another health unit shall transmit the report to the medical officer of health serving the health unit in which the person resides.

The Chairman: Ms. Baldwin?

Ms. Baldwin: With the committee's permission, I noticed that when the motion was read out there was one addition made. On the assumption for a minute that this may pass, I request maybe the mover's permission, maybe that is the appropriate thing to do, to make arthritis which you made (iv) number (iii), and then make the last item be called number (iv) because it is sort of a general, all inclusive and other stuff--

The Chairman: Agreed. Is it just to tidy it up to change (iii) to (iv).

Mr. Cordiano: Fine.

The Chairman: Mr. Andrewes?

Mr. Andrewes: Two points here, Mr. Chairman, I would like to clarify. First of all, on the item we just discussed, arthritis, there is no time limit. I assume because the symptoms do not develop within a period of time or is that an oversight?

Ms. Hart: It is an oversight, and the time limit on it was six weeks. Am I correct? So I guess it would be

arthritis within six weeks after the administration of an immunizing agent.

Mr. Andrewes: To be consistent, 42 days.

Ms. Hart: Yes. Right, we have discussed it, I just forgot.

The Chairman: Forty-two days you would like.

Let's point it out to the members, there is a new subsection 37(a), sub (iii), arthritis, requires a qualification in terms of the time limit, and it has just been an oversight. Apparently it is a six-week period. Mr. Andrewes is suggesting, because we are using days for the others, that we should be consistent and use days here, 42 days. Is that agreed? So the language would now read: Arthritis...

Ms. Baldwin: Arthritis occurring within 42 days after the administration of an immunizing agent.

The Chairman: Okay. Thank you very much, Mr. Andrewes.

There was a second point you had?

Mr. Andrewes: The second point is, I would like to hear from the Ministry their view of the difference between "severe reaction" and "reportable event".

Ms. Hart: We are intending to do that.

The Chairman: Just to make sure, just before we get to that, that will be the first thing we do, I just want to make sure that the language is clear to everybody, that they now understand what has just happened. 37(a), sub (iii) is now: Arthritis occurring within 24 days after the administration of an immunizing agent--

Ms. Hart: Forty-two.

The Chairman: Forty-two days after the administration of an immunizing agent, or, and then what was sub (iii) is now sub (iv) beginning with "generalized", et cetera, et cetera

Mr. Allen, is this part of the language?

Mr. Allen: Just as to why the reportable event of death was left out. I suspect that it has to do with the fact that the death would be a consequence of any one or several of these symptoms that are described here.

Ms. Hart: Right.

Mr. Allen: But I do know that some allergic reactions are almost instantaneous without any intervening time frame to really identify any or all of those symptoms. Would that be some reason possibly nonetheless to include it?

The Chairman: Let's go in order then. We will deal with the question, because that is a substantive matter, it seems to me. Still the question of the definition of why the use of reportable event, rather than that which was presented to us yesterday.

Ms. Hart: Dr. Carlson?

Dr. Carlson: We have it "reportable event" in this amendment so that we can include a wide variety of events which may occur which may not be necessarily considered to be serious reaction. It also ties in with section 31 of the Health Protection and Promotion Act that allows us to include reportable diseases and reportable events.

The Chairman: Do you follow that, Mr. Andrewes?

Mr. Andrewes: Yes. Thank you.

Ms. Hart: It is intended to make it more generic and broader.

The Chairman: Mr. Allen's question on the death question.

Dr. Carlson: That would come under anaphylaxis or anaphylactic shock. It would be the cause of an immediate death following an instance.

The Chairman: It is understood by members?

Mr. Pierce?

Mr. Pierce: The amendments 37(a)(1)-(a)-(1) and the time frames of 24 hours. According to the presentations that were made yesterday, it is not necessary that the parent would be fully alerted there had been a reaction within that minimum period of 24 hours.

Dr. Carlson: It is my understanding that anaphylaxis or anaphylactic shock is defined as an immediate reaction, and it would certainly occur within 24 hours. But persistent crying or screaming I would attribute to a vaccine that might have some temporal relationship if it occurred within 24 hours. I would not anticipate that screaming commencing beyond 24 hours after immunization would be temporally associated with the vaccine.

Mr. Pierce: But I guess the question that that brings up is, is there any documented proof that in fact it hadn't happened within 30 or later?

Dr. Carlson: It is my understanding that the persistent crying or screaming is a reaction that is being temporally reported with pertussis vaccine, and that this occurs within a few hours of the vaccine that is reported. These are times that we have taken from other reports that we have...

Mr. Pierce: Being?

Dr. Carlson: This particular timing?

Mr. Pierce: Yes.

Dr. Carlson: This one comes from the U.S. law that they are considering that time frame, but that is also in other documents.

Mr. Pierce: If that time frame is part of the amendment and becomes part of the Bill, what happens if the reaction doesn't happen within 24 hours, but it happens the following day?

Dr. Carlson: Then we follow it up with any other significant occurrence occurring within 15 days. It would be covered off.

The Chairman: Let's just keep going in rotation here and dealing with the questions if it is all right, and we will get into commentary afterwards.

Mr. Reycraft has a question.

Mr. Reycraft: A question, too, Mr. Chairman. Do we have any way of knowing, and this is to Dr. Carlson, do we have any way of knowing from studies of the reported adverse reactions that symptoms like persistent crying or screaming would always occur within 24 hours after the administration of the vaccine? I guess vice versa, do we know that they don't start beyond that time period?

Dr. Carlson: What we do know is that following vaccines there have been reported episodes of persistent screaming or crying which appear to be temporally related with the pertussis vaccine.

My understanding is that we don't have any way of knowing the time frame that someone who screams at three days and not at two and one is for sure related or not related to the vaccine. I think there is not that kind of knowledge. However, we do cover this in the 15 days.

The Chairman: Mr. Pierce?

Mr. Pierce: Mr. Chairman, in earlier questions I asked about the difference between the proposed amendments by the Association for Vaccine Damaged Children and the proposed amendments by the Ministry. Perhaps now the Ministry could explain in some detail the limitations placed on the Ministry's proposal or proposed amendment as it relates to the amendment as proposed by the AVDC.

The Chairman: Our normal approach, and I apologize to Mr. Cordiano for this, would be to move right into some clarification to the questions, would normally be to have the mover speak to the issue or, if you prefer to have the Parliamentary Assistant speak on your behalf to the issue, and then we will open up to questions. So it would be appropriate now to go to the Parliamentary Assistant. I apologize, Mr. Cordiano, for not doing that before.

Ms. Hart: Mr. Chairman, if I might ask for Mr. Carlson's assistance, what we did in coming up with these amendments was, we went through the proposed amendments by the Association for Vaccine Damaged Children, to determine whether what they said was included within ours or whether we could change ours so that it was. So perhaps the best way of dealing with that is to -- I know, it seems a little odd in terms of procedure -- is to look at the proposed amendments by the Association and relate them back to ours. Would that be satisfactory?

The Chairman: Sure.

Ms. Hart: Dr. Kendall?

Dr. Kendall: If we look at 37(a)(1) and move down the list of reactions, none of these have a time frame temporally related to them; therefore, a child receiving vaccines at two, four, six, and eighteen months, and if we include other vaccines at twelve months as well, it can be expected to have a number of these events occurring in the course of its life completely unrelated to the vaccines. We, therefore, feel it is necessary to try and narrow the time range to bring in a temporal relationship.

Mr. Pierce: Can I ask questions while we are getting the explanation?

The Chairman: I think just for a moment, why don't we try to get a bit of a run through and then go back. If you would like to make a note of them as we go along.

Mr. Pierce: I think specifically, though, as it relates to the time frame issue, and that is as we heard presentations yesterday there were a number of parents that, because of the educational process that is lacking,

the parent did not realize that in fact their child was having a reaction until they saw a television show four or five or six years later, but it was too late.

So do we say by putting the time limits in here that that's too bad. It has gone beyond the time limits, so it is just a tough break that you didn't know about it.

The Chairman: If I might just give order a little bit. I think that is a good substantive matter for debate. I think that what we should probably do now is get what we would usually have had, get the proposer's reasons set out for what they are doing and in large terms and then move to the individual points and the validity from your perspective on what is being proposed, rather than breaking it up all the way through, if that is all right with you, sir.

It is an obvious question that we are going to have to deal with, and it takes an awful lot years of formal education... Why don't we run through to see how the Ministry looks at it, and start by answering the questions by Mr. Pierce.

Mr. Kendall: Persistent crying and screaming is included in the Ministry amendment. Anaphylaxis and anaphylactic shock and collapse is included in the Ministry amendment. Convulsions and seizures are included. We are not sure whether it is necessary to include the complete definition of convulsions and seizures within the substance of the Act.

Dr. Carlson: It might limit. It might limit the reporting of something that might be a convulsion if it doesn't consider to fit. We broadly want convulsions of all types.

Dr. Kendall: We suggested a fever. A definition of fever would include a fever of 104 rather than a fever of 103. The frequency of fevers following vaccinations is high, is admittedly high. I am not sure that we will gain anything by having 50 per cent of all children who are vaccinated being reported to us because they have a mild fever. We see little point in that because it is just so common.

Would you like to answer the next one?

Dr. Carlson: As was pointed out, any acute complication or sequela of an illness, disability, injury or condition which followed any childhood vaccination has no time frame on it, and in that case we would see that any problem arising in the first year of life could be reportable.

Encephalopathy and encephalitis are included in the amendment. The balance of F1 is the definition which we could provide our definition of encephalopathy. The symptoms at the end, high pitch and unusual screaming may or may not be associated with encephalopathy.

F2 and encephalopathy associated with infection, et cetera, would have every meningitis case reported as a potential adverse vaccine reaction. Meningitis is reported currently. It would not give useful information regarding the vaccine because there are other reasons for young children to get these diseases, particularly as there is no time frame.

Death, we felt, would be as a result of a severe complication and need not be included separately. We have addressed that.

The G2 is very complex. Indeed any child who died would be likely to have some abnormality. There is really no evidence that one can pick up from an autopsy and come back and say this was caused by a vaccine; there is no such evidence. So we would see that this would not be helpful as G2, and a child would have to wait until the association was found before or no association before further proceeding with the vaccine.

Loss of muscle control is what we consider shock collapse, we have included that. It is also hypotonic, hyporesponsive collapse. Allergic hypersensitivity reaction is included both in the anaphylactic shock and it is included in generalized urticarias. We have got both the immediate hypersensitivity reaction and the... Severe local reactions, I think that will be up to discussion.

Mr. Kendall: A point would be that they are fairly common, especially with the newer Ajulin (phon.) vaccine that has been in use for the past two or three years. We can expect a lot of them depending on the physician's technique and they are not related to any of the more severe reactions. So I am not sure what we gain by having those in, but they could be included.

Dr. Carlson: Following on to the change in behaviours, sleep patterns and personality is not defined in time. It is difficult to relate those if there is no time frame over the first year of life. There are changes in all children's behaviour and sleep patterns through that period.

The next section, section L, is any illness occurring, as I interpret it, any illness occurring in the first two years of life almost. Onset of any diseases for which immunization has been given is already reportable. All those diseases are reportable.

Onset of arthritis is the one that we realized we have omitted and we have included that.

Hypoglycemia is a sign, a finding which is associated with a shock collapse. It is not a symptom or not something that one would know about other than by the collapse.

The Chairman: In general terms, what we have here is an attempt to incorporate the amendments that were being proposed by the association yesterday, putting them into our particular needs for language with a few omissions because of them either being covered or because of time problems, I am gathering?

Ms. Hart: That's correct. Also there was an attempt by the using of the Rubert reportable event and immunized agent to make it as generic as possible so that it wouldn't give a doctor or anyone charged with reporting a cause, because what he saw wasn't exactly detailed in the legislation, he or she.

The Chairman: Mr. Pierce?

Mr. Pierce: Okay. Again I go back to the question of a parent not necessarily being aware of the fact that their child is suffering from an adverse reaction to the inoculation or any shock until such time as they become aware of it, too. As we heard many parents say yesterday because they saw a program on TV.

Ms. Hart: If I might deal with that, since I think it is more more of a legal question. In talking about reportable events, it doesn't specify anywhere that it is when you found out about the the reportable event. Even if the parent doesn't realize for a period of time thereafter that that is what indeed it was, that onset of those symptoms within 24 hours it is still covered, because the parent remembers that within 24 hours this is what happened.

Mr. Cooke: So it doesn't have to be reported within 24 hours, it has to have occurred within 24 hours?

Ms. Hart: Right. That is my understanding of the language.

The Chairman: Mr. Jackson?

Mr. Jackson: I am somewhat uncomfortable with the legislative explanation of this concept of a reportable event as opposed to a reaction. Not being a lawyer, however, wishing to get a legal reaction, there has to be a distinction in law between -- in a case of litigation, for

example, for medical applications, that something is deemed to be a reaction, it is tied to the active agent which you got a reaction from. Whereas reportable event could be anything that could and could not be related to the inoculation.

I mean a reportable event for the child was that they missed their meal or that they walked funny or may not necessarily be a reaction to the vaccine. Not being a lawyer, I am a little nervous, though, about the explanation. I understand how it is more broadly based in terms of reporting, but in some way does it in any way limit legally the connection between the reportable event and the vaccine or the potential for it being tied to the vaccine?

The Chairman: The Parliamentary Assistant would like to start off in addressing this problem.

Ms. Hart: I guess it depends on how we are viewing this legislation. Are we viewing this legislation as the basis for litigation against doctors, or are we viewing it as a mechanism by which we obtain data, useful data, that enables us to further our knowledge about reactions to these vaccines.

You can deal with the strict legal question, but I have a difference of philosophy than you, perhaps, in that I am viewing it as a piece of legislation to encourage the reporting of these reactions, not to form the basis of litigation against doctors. But perhaps you would...

Mr. Pierce: In respect to that, though, I believe it was you that just offered a legal opinion--

Ms. Hart: Yes, I did.

Mr. Pierce: --of the reason of having the 24 hours in there. In fact in your legal opinion it wasn't restricted to actually making a report.

Ms. Hart: That's right.

Mr. Pierce: So we are talking legally as well as in the form of documentation.

Ms. Hart: I am not precluding the fact that this statute may come into some litigation against a doctor. I am just talking about why are we doing this--

Mr. Pierce: So we have to be careful when we draft the legislation that we protect ourselves in both places.

Ms. Hart: Let's leave it to our lawyers.

Mr. Pierce: You are offering a legal opinion and telling us that this shouldn't be a legal document, it should be one of collecting data. Certainly that was the intent of the Bill when it was drafted. It was always in regards to the data base so that we knew where we were going.

The Chairman: It is always a legal document.

Mr. Pierce: That's right. As long as there are lawyers.

Ms. Hart: We have been dealing with statutes--

The Chairman: That is what we are involved with here as producing these sort of things. But the question, I think, that has been raised is what was the purpose. Was it for collection or was it for use for other purposes?

You are going to have to use my mike, I am afraid, Mrs. Baldwin, just to respond to the legal draftsmanship of this.

Ms. Baldwin: The subsection of the motion that deals with reporting is subsection (2), and that requires the person who would make the report to recognize the presence of a reportable event, that which has been described up above, and form the opinion that it may be related to the administration of an immunizing agent, and once those two things are present, to make a report.

So the person making a report has to say, here is a reportable event; I think it might be related to the administration of an immunizing agent. And at that point the person would be required to make a report. I think legally that is what this is doing.

Now, with regard to the definition of reportable event itself, from my point of view, frankly, just as long as the words 'reportable event' are relatively descriptive, what those words are isn't the serious issue. The serious issue is that which is described after the word "means", okay. And you have your list of what sorts of symptoms or reactions would require a person to take notice and ask himself or herself is this something that might be related to the administration of an immunizing agent.

Mr. Pierce: As a point of simplification, if you are going to include the words "within 24 hours" being a reportable incident, then wouldn't it be proper to also include "but not necessarily reported within that 24 hour period"?

Ms. Baldwin: It is made clear in subsection (2) that the person who makes a report shall within seven days after

recognizing the reportable event. So with regard to making a report--

Mr. Pierce: All right. So it is not restricted then even if it was five years later. Once a doctor became aware of it then he would have to make the report within seven days.

Ms. Baldwin: Once they recognize the reportable event they have to make the report within seven days after that.

Mr. Reyecraft: Mr. Chairman, did I understand Dr. Carlson to say during the first explanation of the amendment that the term "reportable event" was being used to make this amendment consistent with some other part of the Health Protection and Promotion Act?

Dr. Carlson: I believe that hasn't yet been moved.

The Chairman: I guess you would be moving.

Dr. Carlson: We would be moving, yes.

Ms. Hart: I can clarify that if you want to do it now.

The Chairman: I think at this stage that the first motion Mr. Cordiano started to bring in was that subsection, which is the one that is handwritten and not typed.

Mr. Cordiano: yes.

The Chairman: And what I suggest in terms of procedures is that we deal with the substance which is the new definition, and if that passes then go back and make that other change. But that's where the consistency would be. It would be within the new section, not with something which presently exists in the Act.

Mr. Reyecraft: Thank you.

The Chairman: Mr. Pierce?

Mr. Pierce: Mr. Chairman, in discussion yesterday with the Ontario Medical Association, there was some fear within the association, as I understand it, that the amendment, even the amendment or the Bill in fact would be limited to the reporting mechanism being within the jurisdiction of the health unit of the actual incident. And they were suggesting that it had to be or at least should be a provincial-wide reporting system data base. And I have proposed an amendment to section 1 which would remove the words, "in which the professional services are

provided," and substitute the words, "the minister" thereby making it a provincial jurisdictional data base.

Ms. Hart: Might we speak to that?

The Chairman: No, it would have to be moved first.

Mr. Pierce: I would so move.

The Chairman: We have to just change it slightly, Mr. Pierce, this is the first time I have seen it to apply to the specific subsections, which I guess would be subsection (2), I guess.

Mr. Pierce: 37(a), subsection (2).
On the seventh line starting at "The medical officer of health of the health unit in which the professional services are provided," to be removed and substituting the words after there on to "the Minister".

The Chairman: It would be an amendment, just that we need the wording changed, if it is all right, Mr. Pierce, while we have the debate, because I gather the debate will take a few minutes here, at least. What is being proposed, and I don't know how many of you got this, have you?

Mr. Pierce: Everybody should have copies. I believe it was circulated by the clerk.

The Chairman: It is an amendment to section 37a, sub (2), and we are striking out the words following there on (2), which are at the top of page 2, and replacing them with the words "the minister" essentially. It is an order, and would you like to speak to it.

Mr. Pierce: As was discussed yesterday and brought out by the OMA representatives who appeared before the committee, they believe that the Bill, although it was a Bill with good intentions, would still limit the actual reporting to a local health unit and would really do nothing unless somebody was required or somebody drew in all the information that it would do nothing to assist in making a provincial-wide or province-wide reporting system.

In looking at the Bill, I believe that by removing the reference to the "medical officers of health of the health unit in which the professional services are provided" and inserting the words "the minister" would then make it a provincial reporting mechanism.

The Chairman: Thank you.

Response from the Parliament Assistant, and then I will take Mr. Allen. Ms. Hart first.

Ms. Hart: The reason why we kept the medical officer of health as the first line of first reporting station, if I might put it that way, was because that is the mechanism for reporting in the Act as it currently is in the Health Protection and Promotion Act. It was intended by our amendment that it would a provincial data base.

Now, perhaps Dr. Carlson wishes to speak to this as well. Perhaps at the break you and I could have a conversation about this and we could come to some agreement as to how to make it a province-wide data base. But we felt that there was some benefit in giving the information to the local medical officer of health as well.

Mr. Pierce: If I may just offer some comment to that, Mr. Chairman. In looking at the government's proposed amendments, page 2, (3),

"A medical officer of health who receives a report under subsection (2) concerning a person who resides in another health unit shall transmit the report to the medical officer of health serving the health unit in which the person resides".

The onus is on the health unit to know exactly where everybody is living in this province and make sure that those medical records are transferred all over the province. I don't know how we do that.

Mr. Cooke: What happens for reportable diseases now?

Dr. Carlson: That is already the case. If a reportable disease is reported the onus is on the medical officer of health to give the information to the medical officer in the area where the individual resides. It also happens in relation to the immunization record that we require for the immunization of School Pupils Act. I would include--

Mr. Pierce: Dr. Carlson, yesterday we heard comment after comment by parents who said that the health records somehow had been misplaced or lost, and in fact children had received more than their normal share of vaccinations.

Dr. Carlson: I am not talking about health records, I am talking about reportable diseases.

Mr. Pierce: We are talking about the same unit being in control of the records; are we not?

Dr. Kendal: No, sir. We are talking about the child's medical records which are kept with the physician rather than the immunization records which would be collected at school entry, or in a daycare nursery which

would be kept by the local MOH in the area. They are different records.

Mr. Cooke: So if there is a reportable disease, the mechanism now is that the MOH is advised and then the data is collected at the local MOH and is transmitted to the Minister of Health for province-wide status.

I assume that the purpose of your amendment is that exactly the same process would be used. But we don't want the Minister to be the person that collects the data. It is meaningless to people who are located distances from here. It is the MOH that is the high profile medical person on the local level.

Dr. Carlson: Yes. This would allow the personal identifiers, perhaps, to be produced at the local level if there was a record that had to be amended within the health unit, an immunization record, or if they wished to put this on the computer system which it does apply to a number of health units for the immunization record currently, and then the data, when it came to the Ministry of Health, would have the personal identifiers removed. It would be confidentiality.

Mr. Pierce: If this was the case now and a parent moves their child from their home to another jurisdiction, and the other jurisdiction is not aware that the child is suffering from a reaction because it has never been reported as such, and they do not have the medical records available to know whether the child has actually had their vaccinations or not, and then proceed to inoculate the child just in case they haven't, there is no provincial system available to any jurisdiction to allow them to search out that information.

I realize that the intent of having the Minister inserted in that particular part of the Bill is so that there is a central reporting system. There is nothing wrong with the medical health officer also having the information. But there is a central reporting system and there is a data base available throughout the province.

The Chairman: Dr. Kendall?

Dr. Kendall: That is correct. There is currently no system of centralized adverse reactions reporting that would enable a physician who is seeing a patient for the first time to follow and check to see whether that person had had a previous reaction.

Whether such a system could be physically organized with terminals in every doctor's office, and the reports centrally processed into the data lab, accurately available to a physician within two months time, which would be

needed at another end of the province, is something that I am not sure about.

My personal feeling is that a parent should be aware of what the adverse reactions may be and should carry a card with that, and that I think would be much more reliable than a very large computer system with 15,000 subterminals being reliable on everything being reported to it and fed into it.

The Chairman: Mr. Allen has been waiting patiently.

Mr. Allen: I think the answer is reasonable. What the member from Rainy River is asking is a question of tactics and how doctors administer and evaluate what is appropriate for the patients or not.

What I wanted to get back to, though, was what I thought was the central point of his question, and that is whether under the mechanism for reporting reportable diseases and given the phrasing of this particular clause, in fact you understand that the reportable incident will end up a statistic in your hands, so there may be the kind of analysis and province-wide evaluation constantly happening. And, thus, the central part of the question, whatever goes on by way of some elaborate structure to make that accessible to doctors is another question.

The Chairman: Why don't we have a brief response to that now, and then we will break for lunch, returning at 2:00. And I am gathering that there is no difference of opinion in the terms of the attempt to try to get that kind of accumulation of information. Perhaps a discussion can take place during the break and we can come back with a practical solution to this.

Can I have a response from Dr. Carlson or Dr. Kendall?

Dr. Kendall: A centralized data source of reactions occurring within a specified time frame after administration of a vaccine would enable the province to check for rare reactions which had not been reported before and maybe a search for the vaccine. It would enable the province to look at classes of reactions which might be related to a bad lot, and it would enable overall to establish whether the risks of the vaccine, in fact, see the risks of the disease as the disease becomes rarer, so that we have a constant check. It would enable us to do all of those things and that would--

Mr. Allen: That wasn't my question.

Dr. Kendall: that would be the idea of such a central system.

Ms. Hart: We will get to that.

Dr. Carlson?

Dr. Carlson: The medical officers of health do report adverse reactions that they receive to us now. We would certainly anticipate that any legislation would allow this to continue and be reinforced because, I think, it is critical to any program that that kind of data base be achieved.

Mr. Allen: Mr. Chairman, could I just give notice of something that perhaps the Ministry ought reflect on in the break. And that is, I wonder whether, as a new (2) and renumbering the rest of the Bill, whether it would be appropriate to have a clause which tightened up the whole initial reporting; namely, from the parents of the child to the doctor, which would read something like:

Any person administering vaccination shall provide the subject or responsible adult with information as to possible reactions and the importance of reporting significant symptoms forthwith and where such report should be made.

So that you get the earliest possible response and the earliest alert given to the responsible party.

The Chairman: Maybe that could be made, as stated, as a useful suggestion for people to discuss in the break. We have, when we return, a subamendment to the amendment being our focus for discussion. We will have to deal with that matter before we can move on to other amendments to the amendment by the government.

Mr. Cooke?

Mr. Cooke: On the agenda, are we going to the nursing home Bills this afternoon?

The Chairman: No. We are going to them tomorrow morning.

Mr. Cooke: Could I ask then for information tomorrow morning. I think it would be appropriate for this committee to have a full report on the take-over of Country Place Nursing Home tomorrow morning.

The Chairman: Yes.

Mr. Cooke: As it relates to the amendments and how the current legislation worked in that case.

The Chairman: Thank you, Mr. Cooke.

Any other further matters?

Then we will adjourn now and return at two o'clock to continue clause by clause.

---Lunch break at 12:06 p.m.

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

HEALTH PROTECTION AND PROMOTION AMENDMENT ACT

TUESDAY, FEBRUARY 17, 1987

Afternoon Sitting



STANDING COMMITTEE ON SOCIAL DEVELOPMENT

CHAIRMAN: Johnston, R. F. (Scarborough West NDP)

VICE-CHAIRMAN: Allen, R. (Hamilton West NDP)

Andrewes, P. W. (Lincoln PC)

Baetz, R. C. (Ottawa West PC)

Callahan, R. V. (Brampton L)

Cooke, D. S. (Windsor-Riverside NDP)

Cordiano, J. (Downsview L)

Cousens, W. D. (York Centre PC)

Hart, C. E. (York East L)

Jackson, C. (Burlington South PC)

Reycraft, D. R. (Middlesex L)

Substitutions:

Newman, B. (Windsor-Walkerville L) for Mr. Callahan

Pierce, F. J. (Rainy River PC) for Mr. Cousens

Also taking part:

Hart, C. E., Parliamentary Assistant to the Minister of Health
(York East L)

Clerk: Carrozza, F.

Witnesses:

From the Ministry of Health:

Carlson, Dr. J. A., Senior Medical Consultant, Communicable Disease, Disease
Control and Epidemiology Service

Kendall, Dr. P. R. W., Manager, Disease Control and Epidemiology Service

---Upon reconvening at 2:06 p.m.

The Chairman: We return, again, to discuss Bill 52. We are in clause-by-clause discussion, we are discussing at the moment an amendment by Mr. Pierce to the motion. The amendment is: Mr. Pierce moves that Section 37a (2), as amended by Mr. Cordiano be further amended by striking out the words, "To the medical officer of health, of the health unit where the professional services are provided," in line two and be substituted thereto by the words "The Minister."

We have been discussing the appropriateness of the reporting to the MOH up to the point where we broke.

Mr. Pierce: Mr. Chairman, I understand that the Parliamentary Assistant is coming back with a draft of another amendment that may in fact satisfy the amendment that I have proposed and it could be withdrawn so...

The Chairman: So, then why don't you stand yours down--

Mr. Pierce: All right.

The Chairman: --at this stage and then if you wish to withdraw formally after that has been passed, then you can do so.

Mr. Pierce: All right.

The Chairman: We are back then to the main motion made by Mr. Cordiano, the amendment to Section 37a. Any further discussion of the amendment or any part of it?

Mr. Pierce: Well, this is the full thing--

The Chairman: The typed amendment with the one or two small changes in and around the words "arthritis", et cetera.

Mr. Pierce: All right.

The Chairman: Mr. Jackson.

Mr. Jackson: Yes.

Mr. Chairman, my concern is with the 24-hour period in 37a (1)(a) of 1.

The Chairman: Why don't you move the motion and then...

Mr. Jackson: I move that in said Section--

The Chairman: Is that written out?

Mr. Jackson: No, sir.

In said Section that we delete "twenty-four" and insert "fourty-eight."

The Chairman: The motion is to subsection 37a(1),
(a)--

Mr. Jackson: (i).

The Chairman: (i) that the words "twenty-four" be replaced with the words "fourty-eight."

Would you like to speak to your motion?

Mr. Jackson: Thank you, Mr. Chairman.

There was considerable presentation yesterday by parents with respect to the time frame for these specific symptoms and their personal experiences extended even beyond the forty-eight hours, but it was not limited by the twenty-four. In fact, it was the medical responses which they got which indicated by and large that because it was only twenty-four hours probably it will go away.

I quote from the Compendium of Pharmaceuticals and Specialities 1986 which refers to the pertussis vaccine by Connaught under adverse effects. It specifically sets out that these symptoms are most frequent during the first twenty-four hour following vaccine injection and may persist for one to two days.

So, even the pharmaceutical company, in ministerial consultations with the pharmaceutical company, indicate a period greater than the twenty-four hours.

The Chairman: But--

Mr. Pierce: You have heard enough from me, Mr. Chairman, on this subject.

The Chairman: Gentlemen, my policy is--

Ms. Hart: We do not have any problem with you amending to forty-eight hours.

The Chairman: So, let's firm the amendment.

Mr. Jackson: If I would have known that I would have asked for seventy-two hours.

Ms. Hart: Don't push your luck.

The Chairman: So, there is the consensus, I gather, that subsection 37a(1)(a)(i) the words "twenty-four" have been replaced by "fourty-eight."

---(Carried)

Any further debate on Mr. Cordiano's motion? Mr. Jackson.

Mr. Jackson: Mr. Chairman, it will be debate which may become an amendment, but I having increased difficulty with only referring in the body of the Bill reference to a -- former reference to an adverse reaction, or a severe reaction, being replaced by a reportable event.

And I need to be satisfied that somewhere in the Bill we are referring to this as a reaction, a severe reaction, or an adverse reaction. And therefore, if we are going to refer to it then, a reportable event and an adverse reaction, somehow we should tie the two together without limiting the two aforementioned phrases.

But it seems to me that all the parental experiences, all the medical discussion, in fact, even all the examinations for discovery in legal spirit refer to adverse reaction or severe reaction and not a reportable event.

I listened carefully and do understand the legislative counsel's clear explanation with respect to how it fits with the Bill. I do not wish to give you my statements about how unique I consider this situation in terms of the entire Act. But I need to be satisfied where -- maybe I can start by asking counsel if they could tell us where, anywhere else in the Act there is a reference to adverse reaction or severe reaction?

Ms. Baldwin: I think that might be better put to Miss. Wysocki, Mr. Chairman.

Ms. Wysocki: I do not believe that the legislation--

Mr. Jackson, to my knowledge the Health Protection and Promotion Act does not make any reference in the Bill at all to severe reactions or adverse effects at all. The whole reporting mechanism talks about virulent diseases, communicable diseases, and reportable diseases. So that this section would be the sole section in which that terminology might be used in the future.

Mr. Pierce: What we have just heard in supplement to that, Mr. Chairman, through you, in the guide for Immunization for Canadians published by Health and Welfare Canada, on page 17, it refers to "adverse reactions."

Ms. Wysocki: I am not disputing that, sir.

Mr. Pierce: So, that the words "adverse" and "reaction" are coupled in respect to DPT in other drug related instances?

Ms. Wysocki: I was just making my remark in reference to the Health Protection and Promotion Act. I thought that the question directed to me was whether that term is used in the Health Protection and Promotion Act.

The Chairman: It was.

Mr. Pierce: All right.

Mr. Jackson: I am still trying to get someone to jump forward and assist me with some legal wording as how we can merge "a reportable event" and "an adverse reaction." Even if we were to amend what "reportable event" means, and it means:

"An event or reaction which may be the following, but not limited by the following."

I mean, somewhere in the legislation we should be using the words "a reaction" to an injection.

The Chairman: Doctor, somebody will probably refer to you so...

Mr. Jackson: Yes, I am referring it to...

Ms. Baldwin: I could respond to that as I drafted it.

Mr. Jackson: Yes.

Ms. Baldwin: Again, I take you back to subsection 2 and suggest that as the whole motion is structured at this time, what is being anticipated is an event, or a symptom, with regard to which somebody forms an opinion that it may be related to an immunizing agent, okay?

In the first instance you are just looking at the symptom and that is what is now called "reportable event" is referring to.

The step of deciding this symptom is because of an immunizing agent is a logical step that the doctor would take based on experience; it is not part of the definition itself. So, you would be jumping the gun to put that into the definition.

I am not arguing that you could not use words like "adverse reaction", or whatever you wanted to as the words instead of "reportable event." But when you are adding on that other stuff to the definition you are jumping the gun

to what is happening in subsection 2 as it is drafted at the present time.

Mr. Jackson: All right. Well, then tell me, then, why we have got "duty to report reactions"? Why are we using that phraseology and then we quote - then in the body of the clause we refer to "the presence of a reportable event or reaction." Why don't we say "or reaction?"

Ms. Baldwin: Excuse me, sir. It is not "a reportable event or reaction." It is a reportable event that the doctor thinks may be a reaction. Side notes we try to make as brief as possible so that one can quickly flip through the Act and understand what is going on. And it is putting into very few words something that is quite complicated.

The Chairman: Mr. Allen, on this matter.

Mr. Allen: I am not sure that I am beginning to catch the sense of legislative counsel's advice or not. I can see what Mr. Jackson is trying to drive at in terms of making the language a little bit more accessible by rendering it somewhat after the fashion that "a reportable event" means a reaction to a vaccination which would involve, and then the ones, twos and threes.

But do I hear you saying that at the moment you use the word "reaction" you prejudice the issue or...

Ms. Baldwin: Yes, that is what I am suggesting. I am suggesting that I would expect as a practical matter, that when you first see a symptom, and you are a doctor, it is not abundantly clear in the first instance that that is a reaction to an immunizing agent.

Okay? You have a symptom, and then you make a decision, that that is or that is not a reaction to an immunizing agent, okay.

Mr. Allen: Yes.

Ms. Baldwin: The purpose of the definition of "reportable event" is to describe the symptom.

Mr. Allen: So that what you are trying to guard us against is the possibility that one might be limiting the situation by just using the word "reaction"--

Ms. Baldwin: That is correct.

Mr. Allen: --because that involves an intermediary judgment of some kind that clutters the whole situation?

Ms. Baldwin: That is correct.

Mr. Allen: Okay. Thank you

The Chairman: Mr. Baetz.

Mr. Baetz: I think my question was largely answered here. I gather that the main thing here is that all of these symptoms, or whatever you call them, are encompassed in the words "reportable event" and the overall Act, once it's ignored then a whole number of things automatically follow.

So, I do not have the concern that my colleague does with this, not after I have heard the explanation.

The Chairman: Essentially what we are being told is that with this kind of an approach things would be reported which may or may not be attributed to the vaccine, if they fell within the time frames and descriptions - the symptomatic descriptions - that are outlined. And therefore, it is broader than just referring to this as an adverse reaction which is the second stage, which is the value judgment on what has caused it.

Further discussion on this?

Mr. Allen: On this particular point or on Mr. Cordiano's overall motion?

The Chairman: I think we have probably discussed this thoroughly. If Mr. Jackson wants to try to formulate a motion he may do so. Shall we deal with another matter on this as you try to work that up or...

Mr. Jackson: We were dealing with one, two, and three, as I understand?

The Chairman: We are dealing with every number but four, yes.

Mr. Jackson: One, two, and three, okay.

I will dwell on this for a moment, then, Mr. Chairman.

The Chairman: Mr. Allen.

Mr. Allen: Mr. Chairman, as I indicated this morning I would be moving a motion which would be inserted into amendment to Mr. Cordiano's motion which would be an insert 1(a) under 37a, and which would read as follows:

"I move that Section 37a of the Act as set out in the government motion to amend Section 1 of the Bill be amended by adding thereto the following subsection:

A physician or other person authorized to administer an immunizing agent shall, before administering it to the patient, inform the patient, or where the patient is not competent to consent, the person authorized to consent on the patient's behalf, of any possible reactions to it and of the importance of reporting to a physician forthwith any reaction that might be a reportable event."

The Chairman: Mr. Allen, would you like to speak to it?

Mr. Allen: Mr. Chairman, it seems to me that if we are trying to devise a system which records the adverse reactions that do occur following vaccination it is extremely important that that information be forthcoming at the earliest possible moment, not just for the benefit of the subject, the patient, the immunized person, who is having a reaction, but also from the point of view of the doctor being able to respond effectively. And also, from the point of view of the information gathering that provides us with the data base for analyzing how, and why, and to what extent these events are happening.

And it seems to me that the most critical moment in all that really is when doctor and patient, or responsible party, are together; when the event is going to happen and it is abundantly clear, in that situation, what the benefits are and what possible risks attend the event.

So, that the parent in question, or the responsible patient, is able to evaluate the reactions that might happen within the next period of time and conscientiously to get back to the doctor for as early a response as possible. So, that it seems to me that that is the moment at which we need to focus this Bill above all, and I would suggest that this proposal does that.

I understand that the Parliamentary Assistant has some problem with the phrase "possible reactions" and would be interested in seeing some other language such as - and perhaps I am putting words in her mouth, but she may respond to this too - such as both "benefits" and "possible adverse reactions."

And I would like also to hear the response of the medical advice we have got available to us in the room too about that language and whether it is appropriate for medical, professional reporting?

The Chairman: In this matter. Mr. Baetz, was this...

Mr. Baetz: No, no other questions.

The Chairman: Mr. Cooke.

Mr. Cooke: Mr. Chairman, I think the motion is appropriate in that one of the difficulties I have seen with some good health care legislation that have been passed is that quite often the benefits of that legislation are very seldom communicated to the consumers.

The only concern that I have, and perhaps the doctors can respond for me, is that I would hope that the reaction from the Ministry would be some brochure, or something that can be readily available to parents through their doctor's office, but something that also does not frighten people to the point where immunization becomes even more frightening than it is now as a result of the publicity that some reactions or some difficulties children have gotten or have experienced; because we would not want that to be the end result, and I think that is probably the concern that the doctors have.

But I think the intent of Mr. Allen's motion is simple something that at least parents are advised what to look for so that it can be adhered to or reported very quickly. And I see something provided by the Ontario Medical Association which is -- My God if we ever produced a leaflet like this in the election no one would read the thing, there is not even a picture. However, a leaflet, I know that after Bill 94--

Mr. Andrews: What makes you think they do?

Mr. Cooke: Well, that is true. Maybe that is why I got re-elected because I did not read my literature.

The Chairman: They were nice pictures.

Mr. Cooke: Maybe the Doctors can respond and I think that is the intent here.

The Chairman: Let's start off with the Parliamentary Assistant.

Ms. Hart: I have no difficulty with the principle of this amendment at all. I think it is a good idea that we incorporat it. I do have some difficulty with the fact that only "reactions" are part of it; I think that both risks and benefits should be described to parents.

My difficulty is with the words "any possible reactions." There may be a new one that is found subsequent to the legislation and is the doctor supposed to know about that immediately it is found in the literature? That is my difficulty with that one, but perhaps what we

could do is speak to the doctors and ask them for their reaction.

The Chairman: Dr. Kendall.

Dr. Kendall: We would be concerned with any system that emphasized the adverse reactions without also addressing the benefits to be anticipated and attempting to put the two into some kind of a balance. This system I think then becomes what any physician has, is the duty to obtain informal consent before committing any procedure on a patient or on the person who has the responsibility for another individual.

Mr. Allen: I have no problem with altering the language. As I have indicated, I was devising this, of course, in the context of a Bill which was focused on adverse reactions and I was not aware of what other parts of the Bill, or other medical legislation requires, other kinds of information being given about medical procedures.

But if that would not be obvious under the circumstances it seems to me that I am certainly happy to see the language of both "benefits" and "possible adverse reactions."

I appreciate the Parliamentary Assistant's concern about "any" in that there might be a technical question as to whether the doctor might not have read the last published article that was published in Yugoslavia last week of some reportable matter but--

The Chairman: I have a suggestion for you, if you like, then, from legal counsel, always helpful. Striking out the word "any" and then after the word "possible" putting in the words "benefits or adverse reactions".

Mr. Allen: Yes.

Ms. Hart: Yes, okay.

The Chairman: Is that understood by members? That is on subsection 1(a) made by Mr. Allen on the third last line, after the word "behalf" it would then read "of possible benefits and reactions".

Ms. Baldwin: It is adverse reactions.

The Chairman: Sorry, "of benefits or adverse reactions".

And I have Mr. Andrewes.

Mr. Andrewes: Mr. Chairman, I have some difficulty in saying "of possible benefits and adverse reactions". I

guess, it takes away to some degree the argument that there is any benefit and I would suggest that perhaps if "possible" were inserted in front of "adverse".

The Chairman: Agreed, it gives it a nice balance. Agreed?

Mr. Andrews: Agreed.

The Chairman: Thank you

Ms. Hart: Awfully friendly, today.

The Chairman: It is always like this in Social Development.

I gather we have a consensus on that. All those in favour of the amendment, please, indicate? The motion carries.

---(Carried)

So, I understand there is a new subsection 1(a) to 37a.

Going back to the main motion by Mr. Cordiano. Mr. Jackson?

Mr. Jackson: I yield to Mr. Pierce.

The Chairman: Mr. Pierce?

Mr. Pierce: In 37a subsection (2):

"A physician or a person registered under Part IV (nursing) or VI (pharmacy) of the Health Disciplines Act who, while providing professional services to a person recognizes the presence of a reportable event and forms the opinion that it may be related to the administration of an immunizing agent."

And I just would like some clarification from the Ministry what they mean by, "related to the administration of". Are you talking about the actual giving of the shot and it can only be related to the actual administration of the shot and not the drug itself?

The Chairman: I think that administration at this stage would seem to me would have both implications; the actual pin-prick and also the effects of the administering of a drug. When we talk about the administration of a drug we are not speaking of just to do with the taking of a drug.

Mr. Jackson: Can we just bounce that off legal counsel to be sure?

The Chairman: Sure.

Mr. Pierce: It would look to me like it reflects more on the actual person giving the shot than it does the drug itself, or the reaction of the drug.

Mr. Cooke: It is not the needle that causes the reaction, though, it is the stuff in the needle.

Mr. Pierce: No, it doesn't but it could be the giving of the needle as well.

Mr. Allen: Mr. Chairman, isn't the operative word related to, it does not say that this is a strict cause and effect relationship, but it is related to, in a broad sense, the action which involves the administration, the injection, the chemical substance...

The Chairman: Let's find out what Ms. Baldwin says. Let's get the definitive word from a legal expert.

Ms. Baldwin: I would think that that would be interpreted to mean an adverse reaction to the drug itself. I suppose one can never predict how in some unusual cases judges might construe language - and I see your point that it could be so construed - I do not think it would be.

Mr. Pierce: But it could be?

I have some fear of a piece of legislation that could be - and even at this stage in discussion - could be considered as being not what it is intended to be.

Ms. Baldwin: We could also find out what Miss. Wysocki's opinion is on this. I do not think it is a serious risk that it would be so interpreted. If you are concerned I can see if I can--

Mr. Pierce: I am concerned.

Ms. Baldwin: I will see what I can do, if the committee is similarly concerned, to wipe away any chance of error.

Mr. Pierce: Well, maybe it is a reshuffling of the wording. And it may have to reflect on being the immunizing agent as opposed to the administration of the immunizing agent.

The Chairman: Well, the immunizing agent by itself does not have any effect unless it has been administered. I suggest I really think we are dealing with something here which is--

Mr. Pierce: But then you also had "and to the administration".

Mr. Cooke: Mr. Chairman, I am not a lawyer but I cannot see how there can be any confusion at all.

Ms. Baldwin: I do not think it is problem.

Mr. Jackson: I think it is clear in the previous paragraph, Mr. Chairman, that it is a vaccine - or a combination of vaccines administered.

Ms. Baldwin: Thank you.

The Chairman: Yes.

Mr. Jackson: I mean, in the context that that is in that.

Mr. Allen: That is the actual interpretation--

Mr. Jackson: It reinforces it.

The Chairman: Agreed.

Mr. Jackson: I was concern, but I am less concerned having read that.

The Chairman: It is good of you to go back and read the preceding paragraph, I appreciate it, that helps.

Mr. Jackson: I read two before that--

Mr. Pierce: But I am not all that convinced that it means--

The Chairman: Through a motion--

Mr. Pierce: --what it says it's meaning. And that is... Because I read it:

"To be related to the administration of an immunizing agent shall within 7 days after recognizing the reportable event."

And it would appear to me that it is directed at the person that is administrating the inoculation.

Mr. Allen: In that case, Mr. Chairman, "the administrator--

Mr. Pierce: Can you convince me otherwise?

Mr. Allen: --of an immunizing agent" it is not talking about the administration--

Mr. Pierce: It does not say that, it says--

The Chairman: It could be another authority other than the person who administered the actual vaccine who has provided professional services to a person who at that stage believes that there is, related to the administration of the vaccine by someone else, that there was a problem, and that it is important to at that point consider this a reportable event. And I--

Mr. Pierce: Mr. Chairman, it would appear that legal counsel is having a problem with it as well.

Ms. Baldwin: No, I do not have a problem with it.

Mr. Pierce: Well, maybe I am just--

Ms. Baldwin: If it were to say clearly what you are afraid it says it would be saying "related to the manner of administration of an immunizing agent."

I drafted this. At the time I drafted it I did it to tie it in, as Mr. Jackson was saying, with the definition of immunizing agent. An immunizing agent is a vaccine administered for immunization, so I had to tie in the concept of administered for immunization.

I think the only common-sense meaning of the subsection is that if an immunizing agent is administered and there is reportable event, and there seems to be a connection, you make a report. I am not concerned about the interpretation of it, if the Committee is sufficiently concerned I am happy to re-draft it.

Mr. Cooke: We are not.

Mr. Baetz: No, we are not.

The Chairman: I would need a motion of some sort to have that--

Mr. Pierce: Well, Mr. Chairman, I would like to be better convinced by the legal counsel that, in fact, the wording is appropriate and does what it is supposed to do. And that is to protect the person and also to protect the fact that the drug had been administered.

Mr. Cooke: What would you like it to say? She already said it did.

The Chairman: I am not sure how we can help.

Mr. Allen: Mr. Chairman--

The Chairman: Unless I have a suggestion for a different wording from a member, I am really stuck not knowing where to go on this except to say we should be moving on.

Mr. Cooke: Let's take a vote on the Section.

Mr. Allen: Mr. Chairman, just simply to say that the member is under some obligation to convince the committee that there is a problem in the language. And if he has not got an alternative then I really do not think there is reason for us to labour and let's give counsel the task of trying to find something that is not necessary.

Mr. Pierce: All right, Mr. Chairman, we can move on and...

The Chairman: When we come to the votes on that subsection we will--

Mr. Pierce: Yes.

The Chairman: -- proceed in that regard.

Mr. Baetz.

Mr. Baetz: I have one other question dealing with Section two here. And we go on reading:

"Forms the opinion that it may be related to the administration of the immunizing agent, shall within 7 days after recognizing the report of it, report thereon to the medical officer of health of the health unit where the professional services are provided."

Having done all that as a layman I ask the question: And then what? And then what?

Now, is there within the Health Protection and Promotion Act, is there a set down procedure that an MOH must follow when he has received a reportable act or whatever?

Ms. Hart: Might I speak to that.

There is an amendment coming. To answer your question, yes, there is. But to make it very specific there is an amendment coming to Section 31 that makes it very specific that the medical officer shall report to Ministry within 7 days.

Mr. Baetz: Okay, we are going to deal with that?

Ms. Hart: Yes.

Mr. Baetz: Okay. All right.

The Chairman: We do not have it officially before at this stage, but it has been worked upon in the interim.

Okay, anything further on Mr. Cordiano's motion, Mr. Jackson?

Mr. Jackson: Mr. Chairman, as I expressed I wanted to put forward an amendment, but I need legal counsel's assistance with recording it "One of the reportable events/ adverse reactions, a fatality."

Ms. Baldwin: Excuse me, I did not understand?

Mr. Jackson: I would like to put more clearly in the Section 37a(1) reference to a fatality, or a death, as a reportable event. I understood the explanation of this morning that one of anaphylactic shock essentially amounts to death; is that what I heard this morning?

Dr. Carlson: It may.

Dr. Kendall: It may.

Mr. Jackson: I feel that that is insufficient in terms of the breadth of reportable events. Again, I could quote from what the government, the federal government, and Connaught Laboratories advised the medical profession and then it actually states that -- it makes references to fatalities.

The HMO has put out literature that referred to fatalities. The one that we have - the pamphlet that Mr. Smith--

The Chairman: Cooke.

Mr. Jackson: --Mr. Cooke referred to does not refer to a fatality. I feel that this legislation would be deficient if it did not have that.

So, I am asking legal counsel -- We have two challenges; one is to incorporate the concept of a fatality and given that you have put time frames around the reporting mechanism is to overcome the concept of a time frame. I have suggested as potential wording the replacement of - well, let me put it on the record to assist you, Mr. Chairman.

Mr. Chairman: Yes.

Mr. Jackson: I move that Section 37a(1) subset (1)(a)(4) be amended by including, under Section 4,

"Fatality occurring during a reasonable period of time after the administration of an immunizing agent, or..."

And renumbering subset (4) to be subset (5).

So, that just gives us the wording in the form of a motion for us to deal with. I know I am renumbering 4. I making this the new 4 and making the current 4 number 5 because counsel advised us that any other significant occurrences in pure form was best placed at the end of the pecking order.

Ms. Baldwin: Mr. Jackson, I don't know.

Okay, I will tell what is in my head. What is in head is, I agree with you the question is if such an amendment were to be put what the time frame should be? That is a policy question that--

Mr. Jackson: Yes.

Ms. Baldwin: --I am the last person it is up to clearly. I gathered from what the Ministry official said before that it may be that if death occurred from an immunizing agent it would be within what we now have as forty-eight hours, in which case one could simply add -- one could say, persistent crying or screaming, anaphylaxis, anaphylactic shock or death occurring.

But I leave it to the committee to deal with the question of what time frame they think is appropriate for death if death is to be included in the list, and at that point I would be happy to assist--

Mr. Jackson: If I can react quickly, Mr. Chairman. I have no difficulty with that, but then it limits it by forty-eight hours.

Now, the specific case in my community, which was shared with me, which was that the death occurred within six hours of the inoculation. And it certainly, as the case that I am most personally involved in and aware of, it would fit. But it has been equally shared with me cases that do not fall within that forty-eight hour period, and therefore, I am nervous about--

The Chairman: Why don't we get some advice--

Mr. Jackson: --legal counsel's suggestion. And I also would like advice on the use of the word "fatality" or "death." I guess "death" is the proper legal term?

The Chairman: Ms. Hart.

Ms. Hart: Mr. Jackson, my interpretation of what is now subset 4 "any other significant occurrence" would include death. But I do not think we would have any occurring within 15 days. I do not think we would have any difficulty if you want to spell it out at that point "any other significant occurrence including death occurring within 15 days." That gives you a much broader range of time.

Mr. Baetz: Weren't we also told sometime this morning that if a death occurs that there is a whole other serious of -- chain of events, or of reporting, that follows automatically in any event?

Ms. Hart: Yes.

Mr. Baetz: When I heard that I was not as concerned about including it in this legislation. Now, maybe...

Mr. Jackson: I think, Mr. Chairman, we are half way home. We have got agreement that there is no objection to including a reference to death as an adverse reaction.

The Chairman: Well, how do you feel about the suggestion of placing it in the present sub 4?

Mr. Jackson: Before I would agree to that I would like a reaction to my suggestion which was the policy question with respect to a reasonable length of time? And that is why I chose to set it out as a separate motion for that reason.

The Chairman: Do we have any information?

Ms. Hart: I have a reaction to that. We are trying to make it as precise as possible so that the people charged with the responsibility for reporting know when they have to report. If you say, "within a reasonable length of time" it is open to every individual physician's interpretation as to what "reasonable" is. I think we get a much better system if we make the period of time "a reasonable time" and put it right in the statute.

Mr. Cordiano: Was it not also an issue. The issue was, how do you relate a death occurring to the possible toxicity of a vaccine causing that death? Was that not the cause and effect relationship that was difficult to determine in this instance?

The Chairman: Could one of the doctors give us an idea of the information on when deaths occur?

Dr. Kendall: Death can occur at any stage during infancy, but presumably we have here a death that followed within a very brief period of immunization must be due to

an anaphylactic shock and so there would be recognized predisposing cause.

If the death followed any of the other reportable events then the reportable events self-precedes the death, the death is an outcome. They would both be reported together.

If we are looking at deaths that occur with nothing symptomatic intervening between the injection and the death then you are linking in a large number of other deaths. I know, I suspect that perhaps this is a follow-up on the thesis that has been raised, that sudden infant death syndrome which by definition is a sudden death in an otherwise well infant has been linked to DPT. Case control studies in the States and Europe have dispelled any increase in sudden infant death syndrome following DPT, actually with pertussis.

So, if we are looking at capturing deaths in children who were previously symptomatic and linking them to the vaccine, there is a little technical problem with that, I think. I would assume that any death that was linked to the vaccine would have some intervening cause or else it would be so proximate to the event that it would be obvious and we would have it.

The Chairman: Mr. Cooke.

Mr. Cooke: Mr. Chairman, I am getting concerned that if we start expanding and we start saying that if some doctor makes some connection and therefore it is reportable, and we start getting statistics that perhaps could be meaningless, what we are really doing is designing a piece of legislation that scares people away from being immunized rather than, what I understood, the purpose of this legislation and that was to simply gather data.

So, I agree with the doctors. I think that it is well covered in the proposal by the Ministry and I would be reluctant to add any reference to death since we have the pre-conditions already covered.

The Chairman: Further discussion on Mr. Jackson's motion? Mr. Jackson.

Mr. Jackson: I find acceptable the suggestion by legal counsel to possibly modify the existing Section 4 to state; "Encephalitis, or death, or any other significant occurrence within 15 days." I feel so very strongly about having a certain--

The Chairman: Are you withdrawing the--

Mr. Jackson: I withdraw and I am replacing it. I understand the policy problems with it being open-ended and

I respect Dr. Kendall's explanation, it is hard to argue with that logic, but I disagree with Mr. Cooke. I think the legislation should have a certain degree of clarity for the general public.

And I take quite personally the fact that the experience that I was shared with, where the mothering ability was called into question by the physician when the... I mean, it was very clear - I do not wish to burden the committee with the experience - but there was such an effort including not allowing the autopsy, not allowing the reports, and not even allowing the mother to get a death certificate for her baby.

This is a very, very serious case that was presented to me in my community. And the fact is, is that everybody tends to avoid this issue. If there is a reason for it please enlighten me. But as I see it, it is a reality, no one is disputing it, and it therefore should be clearly set out in the literature and in the legislation. And to do otherwise, in my view, would not be fair to those parents who want all the facts, with respect. And to expect the general public of Ontario to understand that anaphylactic shock in most cases results in death is, in my view, false but--

The Chairman: It does not, but it always comes before death, is what has been said. It does not always result in--

Mr. Jackson: Well, so does shutting your eyes, Mr. Chairman. I really request that the committee seriously consider the resolution.

The Chairman: Try to clear up the--

Mr. Jackson: The amendment.

The Chairman: The new motion by Mr. Jackson would amend present subsection 4 so that it would read "generalized" after the words "encephalitis, death or any other significant occurrence." Ms. Hart?

Ms. Hart: I am persuaded by Mr. Cooke and Dr. Kendall that there is not enough nexus between death and the symptoms that I would not be in support of Mr. Jackson's amendment.

The Chairman: Mr. Baetz.

Mr. Baetz: Can I ask Dr. Kendall a question.

When there is a mysterious death of an infant, is it normal that among the many questions I would presume that would be asked about, you know, what happened to the child

before, and everything else, that automatically the question would be asked: Has this child been vaccinated in the last fortnight or so? Would this be part of a normal post-mortem examination or not?

Dr. Kendall: I can't answer that question. I don't recall now, I believe a post-mortem -- I would imagine so, every fact relevant would be brought forward.

The Chairman: Mr. Pierce.

Mr. Pierce: Mr. Chairman, a question of Dr. Kendall. Are there any recorded deaths as a result of vaccination?

Dr. Kendall: In the literature? The risk is cited in the literature as existing.

Mr. Jackson: You don't have a reported case in Ontario ever of a death associated with a vaccine; is that what you are telling us?

Dr. Carlson: An immediate death.

Mr. Jackson: I am sorry?

Dr. Carlson: An immediate death.

Mr. Pierce: Any death?

Mr. Jackson: That is incredible, absolutely incredible.

Mr. Pierce: Any death, Doctor, whether it would be immediate, or three days later, or five days later, we are playing with words. Are there any reported deaths as a result of vaccination in the Province of Ontario that you are aware of?

Dr. Kendall: Not to my knowledge.

Dr. Carlson: Not in the records that I have. There could possibly be a report of an encephalitis which was associated with immunization or a complication following a temporally associated vaccination in a child who went on to die. I have not got that in the reports that I have but...

Mr. Cooke: So, what you are saying is that if a child -- encephalitis resulted from the vaccination then that is reportable and if a tragedy occurred that it got worse and there was a death, then, obviously, that would be the stages that it would be reported -- that it would be caught by this legislation because of the encephalitis?

I mean, I think we have got to be very careful, and I

hope that no members of this Committee are saying that immunization is inappropriate. We do not want to build all sorts of scary things and scary statistics that people are frightened away from using this process. It would be inappropriate to scare people on inaccurate statistics. And when you build in the kinds of criteria that you want in this legislation then your statistics, I think, are going to be completely inaccurate.

The Chairman: Yes, Mr. Jackson.

Mr. Jackson: We are not talking about statistics, we are talking about facts. The fact is, is that in Canada there have been reported cases of death associated with this vaccine. The two - without getting into the credentials of our two expert witnesses from the Ministry - we are advised that to the best of their knowledge it is unknown. That is the extent to which you are going to professionally apply your credentials to that statement?

Dr. Kendall: We currently in our records have no records of deaths due to DPTP in Ontario.

Mr. Jackson: All right.

What I am telling you is that the Federal Government is making a statement that it is, and so is Connaught Laboratories, and so is the -- I will read you the direct quote from the Compendium of Pharmaceuticals and Specialties; and yet, for some reason this government, I mean, why are we doing this if we are not going to at least advise the medical community that in fact fatalities are a reportable incident.

The Chairman: Surely the issue we have before us, as I see it, is how we are sure whether or not a death is actually reported as part of the reportable incident. It is unforeseeable, except perhaps in infant death syndrome, if somebody wants to make those arguments about connection, that a child would die without exhibiting some of the symptoms that are already listed in a reportable event that we have already got.

The question that the arises in my mind about what Mr. Jackson is raising is, just because that would become a reportable event - the shock that the child may go through - would in fact, the subsequent report be made about the child's death, if the child were to die within 10 to 15 days. And that is what I am not clear about in the way we have set this out at the moment, that I could use some guidance on.

Are we sure that the child that had the shock, that became a reportable event, will also in the provincial records wherever they are held, if that child were to die,

also indicate that that child had died? I am not sure of that?

Dr. Kendall: The intent would be to capture that, certainly.

Mr. Cordiano: How is it captured? I am a little confused now at this point, too.

The Chairman: I guess I want to know that what we set up here is something that has a continuum to it in terms of the report, in terms of the subsequent symptomology that may show itself, and say the child died 20 days later because of extraordinary efforts that were made to keep the child alive, or whatever, would that death show as a statistic and therefore reportable diseases under the Health Protection Act now?

I mean, for example, on the disease that receives a fair amount of publicity these days, on Aids, statistics are kept on the number of patients that had the disease and statistics are kept on the number of deaths as a result of the disease. But the Health Protection Act does not say that there has to be a report of a death, the Health Protection Act says that the disease has to be reported.

Ms. Hart: Dr. Carlson I think can help us on this.

Dr. Carlson: And the death.

Mr. Cooke: It does specifically say the death?

Dr. Carlson: Yes, there is a duty to report the death in Section 31.

Mr. Jackson: So does the America plan, Mr. Chairman, and the Quebec plan. I am merely hoping that the Ontario plan would set that out as well.

The Chairman: I am just trying to understand whether or not it already does in the sub -- if we were to establish what we have already done here without Mr. Jackson's amendment. Do other Sections within the Act guarantee that a subsequent death would also be reported as a part of this report on the effects of the -- or the possible effects of the immunization? Are you sure about that, Dr. Carlson?

Dr. Carlson: I would anticipate the reporting would be done in a regulated form, in regulation. In the current form that we have, we have a Section dealing with outcome which is recovered with the residual effects fatal and unknown. Anything that comes back that is not yet recovered is followed up. That is how I would see it addressed.

Mr. Cooke: Well, if Mr. Jackson - I mean, okay, if this is a matter... What I want to keep away from is that we are not reporting a death that may not have had any pre-existing conditions. So, if there is some way of wording it so that after the reportable event takes place that as a result of any of these reportable events a death occurs, that the death is also kept as statistic, fine.

But we want to keep away from children that unfortunately die from completely unrelated things, but it may be 15 days after an immunization shot and we do not want those deaths to be included in these statistics. I think that is the concern I have.

Mr. Jackson: Well, I do not want to get into a discussion about if we are going to be measuring at any point risk here, which is the purpose of this exercise. Surely, when it comes to two and three month old babies we want to err on the side of maybe having too many deaths than not enough. If we are going to in any way measure the amount of risk that we are putting the children of Ontario to. I mean, that gets into a moral argument.

The Chairman: Dr. Kendall?

Dr. Kendall: Almost any child under the age of a year who dies in Ontario will have died within a relatively short period of a vaccine, given that the vaccines are given at age two, four, and six months. The only way to assess the relationship to the vaccine would be to have another cohort of unvaccinated children to see how many of them died during that same period of time and compare the death rates between the two groups.

This has been done with cohorts of children vaccinated and vaccinated with pertussiss. I am unaware of any significant statistical difference in death rates between the two cohorts of children. I understand the point that you are making, sir.

Mr. Pierce: Doctor, if I understand what you are saying, then, that it is very difficult to conclude in that first year of a child's life whether in fact death can be attributed to the actual vaccination because it is done three times in a period of six months, and that there could be other causes of death also. So, that we are prepared to accept that it may have been something else as opposed to being that of the vaccination.

And The only way that we could come to any conclusions in that, if I understand further what you are saying, would be to take a block of children and not vaccinate them and see if they live longer? If they live through that first year?

The Chairman: And you say that has been done? That there are studies--

Dr. Kendall: We have studied the incidents of sudden infant death syndrome which has been linked, or was linked - was postulated that sudden infant syndrome may have been linked with antecedent receipt of DPT. And that something in the DPT caused the sudden infant death syndrome.

They have studied children who received and did not receive a vaccine in a case controlled study and there is no excess receipt of pertussis in children who died just after receiving it. I am getting a little confused here, they did not find that children who had Sidx, S-i-d-x, where more likely to have received the pertussis vaccine than children who did not receive it.

Mr. Pierce: Let me ask you, what would trigger an investigation in a given period of time, say, over a period of a year? If there were two, three, four, five, or six children who died in the span of a year that all had been inoculated by the same block of vaccine, would that trigger an investigation by the Ministry?

Dr. Kendall: That should trigger an investigation, yes.

Mr. Pierce: But would it take the four--

Dr. Carlson: It would depend what they died of.

Mr. Pierce: --how many would... But if we do not know what they died of, we assume that they could possibly die from any number of problems in the first year?

The Chairman: I am wondering if this might help our discussion on this because it seems to me that what we are interested in doing is: One, having recognition of the ultimate serious consequence which might come from the vaccination which is already recognized in medical journals, but we do not want it to necessarily be developing statistical information that is not directed to the symptomology and the effects that we think are there.

What about a suggestion from legal counsel, here, which I would just through open rather than asking any sort of withdrawal at the moment of the other motion which is slightly different, would be that we have to new Section 5 which would say:

"Death occurring at any time and following upon a symptom described in the subclauses that are above."

So, that we are saying that there would have to be the shock, or something like that, which would have triggered the report, and then you are getting the follow-up of that.

Mr. Pierce: Yes.

The Chairman: Would that be appropriate? Would somebody like to move--

Mr. Jackson: I will withdraw my amendment and replace it with that one, Mr. Chairman.

The Chairman: Okay, let's move on Mr. Jackson's-- And you are suggesting this be the final sub 5 now, are you? This will be the new 37a(1)(a)(5) would be as I read it. All those in favour? Carried.

---(Carried)

Mr. Pierce.

Mr. Pierce: A further question, 37a (ii) and the reference to time is three days and in the American Bill they separate the vaccination for mumps, rubella, measles, and so on, and require 15 days.

I just wonder if the Ministry has any comment on that, that three days does not seem to be the appropriate time for everything, but in fact the Americans have recognized that residual seizure disorder in accordance with subsection - of course, they refer to their section here - "15 days for (mumps, rubella, measles, or any vaccine containing any of the foregoing as a component), three days or DTTD, or tetanus toxicide."

The Chairman: In Ontario then it would distinguish between these of earlier childhood ones and the--

Mr. Pierce: Yes.

The Chairman: The mumps, the MP -- whatever it is, follows the first year--

Mr. Pierce: My concern is that, I am very concerned about the time limit restrictions that are being requested by the Ministry and there are recognized facts that some vaccines take longer to react.

The Chairman: Any response from the distinction made in the American sector?

Dr. Kendall: We have taken 15 days which is in subsection 3.

The Chairman: 2.

Dr. Kendall: 2.

Dr. Carlson: 2.

Mr. Pierce: Subsection 2. You're limited to 3 days, it says "shock-like collapses." Now, shock-like collapses, residual seizure disorder is three days, but clarification for the vaccines for mumps, rubella, measles, and so on require 15 days?

Dr. Carlson: Residual seizure disorders.

Mr. Pierce: Yes.

Dr. Carlson: We had considered that this being residual we can certainly - I think that this is a slightly different application. This is a vaccine injury tabled for compensation purposes and we amended it using also some of the documentation we have in the literature. I am not sure that a residual seizure disorder--

Mr. Pierce: Would there be any reason, Doctor, to object to having that inclusion in this--

Dr. Carlson: No, I think that would be acceptable, I am not sure - yes, it could be added to Section, now, 4, I think.

Mr. Pierce: I would feel much more comfortable if it were.

Ms. Hart: So, where do you add it here?

Dr. Carlson: "Generalized urticara..."

The Chairman: How are we going to do it. This is to add the 15-day period for residual seizures rather than - because we do not do it anywhere else. We do not distinguish between the two shots any place else, the two kinds of immunizations.

Mr. Pierce: No.

The Chairman: Now, if you would add -- it has been suggested by the Parliamentary Assistant that we add it to subsection 3.

Ms. Hart: Now, 4.

The Chairman: Now, 4, sorry, right after "urticaria" there would be "upon residual seizures--

Mr. Pierce: I wonder, Mr. Chairman--

The Chairman: --disorders" and then go on to the others.

Mr. Pierce: I wonder, Mr. Chairman, if we could do it something along the same lines that the U.S. Bill is structured on. And that is in 2, you make reference to a subsection that would include and go beyond, and provide for the 15 day extension?

Ms. Hart: We have some difficulty with that, Mr. Pierce, because the amendments have not been structured so that they are separated out by a different kind of vaccine. And as Dr. Carlson has pointed out what you are reading from in the American legislation is a totally - it is not designed for the same purpose, it is their schedule for compensation.

The Chairman: But if we were to place it in the category of symptom, which is not in ours, if you were to place that category symptom in the sub 4, where we have the 15-day period, that would add that--

Mr. Pierce: All right.

The Chairman: --that category. So, it might catch it the same way, but we would have to change our entire wording if we were then going to--

Mr. Pierce: All right.

The Chairman: --separate the two vaccine types out.

Ms. Baldwin: Is it residual seizures?

Ms. Hart: Seizure.

The Chairman: Disorders.

Ms. Hart: Disorders.

The Chairman: So, the wording would be "generalized urtercaria" and then "residual seizure disorders" and then going on to the others.

Ms. Baldwin: Disorder?

The Chairman: Seizure disorder, singular.

Ms. Baldwin: Singular?

The Chairman: Yes.

Mr. Pierce: Doctor, does it require clarification as it respects any particular vaccine?

Dr. Carlson: No, I think in the U.S. legislation they have a limit to the residual seizure disorder following DPT vaccine of three days.

Mr. Pierce: Yes.

Dr. Carlson: And what this is doing is it extends it to 15 days. In our reporting requirement it would be quite appropriate to have it extended, we do not want a limit.

Mr. Pierce: Okay.

The Chairman: So, we have a consensus on that.

I hesitate to ask, but is there anything else on Mr. Cordiano's motion?

Mr. Pierce: Well, just, Mr. Chairman, before we leave the motion, we have my first amendment to the amendment and I understand that the Ministry was coming back with an amendment to cover off the amendment that I have to the amendment to cover the Bill; is that right?

The Chairman: We will deal with this seperately though. If you want to have a look at it, we cannot deal with this while we have the other on the floor; it is not the same Section.

Mr. Pierce: Well, this is...

The Chairman: So you would be adding to Section 31 which we do not have before us at the moment so I cannot - we have to deal with this subsequently. We would have to, you know what is coming, okay, if you like the idea--

Mr. Pierce: But if I lose it how do I bring it back?

The Chairman: Well, you could bring it back as an amendment to this particular-- I mean, if this is acceptable to you it will be removed by the government anyhow so that it is just a matter of going along with it and then you may try to amend it further if you would like to.

But, Bobby, basically what is being said here is that it is better done at another Section because that speaks that I cannot deal with it under 37 of this Section at this time. I have to deal with 37 first.

Mr. Pierce: Right.

The Chairman: Is there anything further on Mr. Cordiano's motion as amended? Because we dealt with it in such detail do you need me to go through each of the

subsections now or do you want me just to take it as amended entirely?

Ms. Hart: As amended.

The Chairman: Okay, as amended, thank you.

All those in favour of Mr. Cordiano's motion as amended please indicate? The motion is carried unanimously.

---(Carried)

It was a little late, but we carried your motion unanimously, Mr. Cordiano.

Now, which would be the next one. Maybe we should deal with this one that has to deal with Mr. Pierce's concern which is to be moved by -- you can move if you like because... We are back to the initial one we did - oh, this is it, isn't it? Do you have it there before you, Mr. Cordiano? Do you want to read it into the record as the one that replaces your handwritten one?

Mr. Cordiano: I move that Section 1 of the Bill be renumbered as Section 1(a) and that the following Section be added to the Bill:

One, Section 31 of the Health Protection and Promotion Act, being Chapter 10, is amended by adding thereto the following subsection;

Two, every medical officer of health shall report to Ministry within seven days after reviewing a report concerning a reportable event under Section 37a that occurs in the health unit served by the medical officer of health.

The Chairman: I have one change, it is "received." The word "reviewing" should be "receiving"

Mr. Cordiano: "Receiving". Did I say reviewing?

The Chairman: I can that the member from Riverside is noting something which I don't want him to note. And that is that we are dealing with a Section which is outside of this Bill that has been brought before us, but that is...

Mr. Cooke: Public curiosity, how do we do that?

The Chairman: If we have unanimous consent of the members to do so and of the Ministry of the--

Mr. Cooke: I am just thinking of another Act that is coming before us tomorrow, that there might be other sections that we might want to do the same thing to. And I hope that if we are co-operative today we will be over it in three weeks.

The Chairman: The only way this kind of a motion can be in order is if there is unanimous consent on the committee to undertake it and if the Ministry agrees that it is acceptable. Since it is coming from the Ministry we know they are - it is then a matter of determining, if I might, before I rule whether it is order or not, whether or not the committee agrees to proceed with it.

Mr. Pierce: Just let me ask, Mr. Chairman, before we do that. The amendment that I proposed in Section 37a(2) was that we strike out the words of my proposed Bill, private members Bill, and insert the words "The Minister". And I guess what I would request rather than to complicate matters, why is that amendment not acceptable to the government or to the Ministry?

Mr. Cordiano: I think that was addressed earlier, Mr. Chairman, with respect to my colleague. According to the Minister I think it was - I should defer to the--

Mr. Pierce: Well, maybe legal counsel could provide us with the proper insertion of the word or maybe there has to be a Subsection 2(a) and (b) in 37a?

Mr. Cooke: Let's proceed the way it's proposed. I was just curious.

The Chairman: I think, if I might just try to help. We will proceed with that which has been read by Mr. Cordiano at this time, if there is unanimous agreement. You can try to amend that Section, if you wish, to meet your needs. If you do not feel that is appropriate I said that you could stand down--

Mr. Pierce: Yes.

The Chairman: --what you did before until you have seen this and reacted to it and we can then go back and reopen that one subsection which you were going to amend and re-introduce your motion, if you choose to, if you are not satisfied--

Mr. Pierce: All right. I just thought it might be less complicated if we did this one first.

Mr. Cooke: No.

The Chairman: My difficulty is at this stage we have moved that the MOH was going to be used. Now, this is

clarifying that the MOH must report back to the Minister. If that is not -- if that were to carry there would really be no point as far as moving your motion because it would have been accepted. So, we might as well have the debate on the two approaches under this Section and move from there.

Mr. Cordiano, do you wish to discuss your motion or the Parliamentary Assistant?

Mr. Cordiano: I will defer to Ms. Hart.

Ms. Hart: The mechanism of reporting currently in the Act for other events which must be reported, such as communicable diseases, is to go through the local Officer of Health. And it was considered by the Ministry that it is much more likely that physicians will report to a local place, to the Medical Officer of Health, with whom they are familiar, they do not have to make a long distance call.

In fact, the procedure now is that the Medical Officer of Health reports to the Ministry, but we have noted the concern of at least some of the Committee members that it be made more formal in the Act, and that's why we came forward with this amendment.

And also, there is no time limit currently for that reporting. And in conversation with Mr. Pierce it was thought that that might be a friendly amendment.

The Chairman: Discussion? Mr. Pierce.

Mr. Pierce: I have no objection to the amendment, Mr. Chairman, and I would be prepared to accept it.

The Chairman: All those in favour? Agreed, carried.

---(Carried)

Are there any further amendments?

Now, as I recall we have amendments to Section 2.
Mr. Cordiano.

Mr. Cordiano: I move that Section 2 of the Bill be amended by striking out "a severe reaction to an immunization against diphtheria, pertussis and tetanus" in the third and fourth lines, and inserting in lieu thereof "a reportable event following the administration of a immunizing agent."

The Chairman: Any discussion?

Ms. Hart: The intent, again, was to bring all of the sections of the Act into some consistency and to make sure

that we were not - we were broadening the Act to include all of the immunizations and I think that is it.

The Chairman: Is there any discussion? No, discussion?

All those in favour? Carried.

---(Carried)

And there is an amendment to Section 3. Oh, sorry, Section 2 is amended and carried. Section 3, Mr. Cordiano.

Mr. Cordiano: I move that Section 3 of the Bill be amended by stricting out "a severe reaction to an immunization against diphtheria, pertussis and tentanus" in the third and fourth lines, and inserting in lieu thereof "or a reportable event following the administration of an immunizing agent."

The Chairman: All those in favour? Carried.

---(Carried)

All those in favour of Section 3 as amended? Carried.

---(Carried)

The Chairman: Legal counsel now.

Ms. Baldwin: Mr. Chairman, just by way of clarification I propose to make one editorial change that I want to call to the Committee's attention. And that is now that we have inserted a new Section 1 of the Bill, the Section which has Section 37a in it will now read "The said Act is amended."

The Chairman: Oh, I see, thank you. An editorial change.

Mr. Pierce: In another editorial change in 37a (2), the third last line "recognizes the presence of a reportable event" as opposed to--

Ms. Baldwin: Yes.

Mr. Pierce: --as opposed to an reportable.

Ms. Baldwin: I have noted that as well, sir.

The Chairman: Sub-section 4, all those in favour? Carried.

---(Carried)

Sub-section 5, all those in favour? Carried.

---(Carried)

Now, the Bill as amended be reported or shall be carried. Mr. Reycraft, sorry?

Mr. Reycraft: I was just wondering about another motion that I think had passed, Mr. Allen's motion I believe was carried.

The Chairman: So, shall the Bill be reported with amendments. Agreed.

---(Bill reported with amendments)

Thank you members.

Mr. Cooke.

Mr. Cooke: Do you have something else or can I raise something for tomorrow?

The Chairman: I think I have nothing else on Bill 52 except to thank the members for their work and the various witnesses who have come before us, and the staff for their assistance, and as usual Ms. Baldwin, as always, for her immediate capacity to respond to our whims.

Mr. Jackson: Very helpful. She is so helpful to the opposition, I am surprised she is still working in the Ministry.

Mr. Pierce: Let me once again, Mr. Chairman, thank the Committee on Social Development for moving the Bill forward in your agenda. And also let me recognize your willingness to share in the expenses of the two people from my riding, Mr. and Mrs. Tetu, and also to thank them for their worthwhile presentation.

And as I said earlier in comments, that it is only a small step forward, but we are progressing and hopefully some day we will be back here making recommendations for a compensation, a no-fault compensation package so that some of the problems that are related to parents that are those parents of damaged children have some relief as well.

And again, I say thank you, and thank you to the Minister.

The Chairman: Thank you, Mr. Pierce and we will be sending you a bill for half their travel while...

Mr. Cooke, proceed your motion for tomorrow.

Mr. Cooke: Well, I just want to get clarification from the Parliamentary Assistant to make sure that tomorrow morning at 10:00 we will be able to get some kind of a briefing on Country Place, the takeover at Country Place. And that there will be staff here to answer any questions about the Country Place takeover since I think it is only the second time that a nursing home has been taken over and the Act under which it has been taken over is one of the Acts under review.

I think it would be helpful to the committee, there has not been a lot in the newspapers and all we have gotten is one press release that does not really go into a lot of detail. So can we be assured that we will get that briefing tomorrow morning at 10:00?

The Chairman: Ms. Hart?

Ms. Hart: Mr. Cooke, your question before lunch was would there be a briefing? And I propose to do a briefing. I did not enquire about staff because I did not read that into your question. I will enquire and if at all possible I will have staff here.

Mr. Cooke: I assume that there will be staff here tomorrow in any case?

Ms. Hart: Yes, but I am not sure it is the same staff, that is all. I will do what I can.

The Chairman: The other thing that I would suggest is that perhaps we could have the briefing in morning. We do have the Ontario Nurses Association on at eleven. We have actually bumped them because of some confusion about who would be having carriage of the Bill and at what time we will actually be starting. I would be a little reluctant to move them again.

We have the Ontario Nursing Home Association in the afternoon which admittedly might take up almost the entire afternoon, but perhaps if we cannot complete the discussion of the take-over of this specific home before the Nurses Association comes on we might continue with that discussion.

Mr. Cooke: What exactly did the Parliamentary Assistant intend to do between ten and eleven o'clock?

Ms. Hart: I have an opening statement.

Mr. Cooke: Not an hour, I take it?

Ms. Hart: No.

Mr. Cooke: I mean, we all went through second reading. I think, I do not know whether Mr. Andrewes wants to raise a concern that he has expressed because I want to support him.

The Chairman: Oh, by God, then he is bound to want to raise it now.

Mr. Andrewes: This is part of a new alliance, Mr. Chairman -- June 29th, Mr. Pierce's birthday, so...

Mr. Chairman, I do not want, you know, to suggest for a moment that I am insulted by any activities in terms of what is going on in this committee. But I have to express some concern with respect to the fact that this legislation that is before us tomorrow being probably the fourth major piece of legislation put forward by the Ministry of Health now in some 16 months does not, apparently, deserve the attention of the Minister himself.

I am not suggesting that Ms. Hart cannot express the Minister's views competently and adequately. I simply feel very strongly that at the outset - in the introduction of this legislation in this committee - that we deserve the presence of the Minister and his attention through specifically the opening comments that he might make.

And I think that is an issue that deserves some attention of the Committee and it deserves perhaps the views of this Committee expressed to the Minister in that regard.

Mr. Cooke: Mr. Chairman, I would just like to add that in addition to the fact - and these are the first amendments to the Nursing Home Act since the Act was introduced in '72 - these are amendments that have been promised to us for nearly two years by the Minister and I am not expecting that the Minister would be with us for four weeks.

But the opening day, I think it be would be appropriate, and especially if we are going to have a discussion which I think would be appropriate on the Country Place take-over, which was obviously a major decision on the part of Minister directly, that I think it be would be appropriate for him to be here tomorrow morning to give an opening statement and to brief us on the Country Place situation.

The Chairman: I have no personal knowledge of his availability unfortunately, so I...

Mr. Jackson: Does the Parliamentary Assistant?

Ms. Hart: I understand that he is not available

tomorrow morning. He intends to be here as much as he can tomorrow and also with respect to certain of the briefs that are to appear before the Committee. But I believe that I am correct in saying that tomorrow morning is not an option.

The Chairman: But he may be here tomorrow at some point?

Ms. Hart: Yes, at some point.

The Chairman: Well, if that is the case might I suggest that tomorrow, perhaps at the beginning of the afternoon session or, if he arrives then, or sometime during that period because we only have the one deputation, although, as I say it might easily fill up that entire time that you may want to raise this matter with him at that time. Perhaps at that stage we can work out a schedule which the Minister will be with us and give you ample opportunity to have at him. How is that?

Mr. Andrewes: That's fine

The Chairman: That is the best I can do.

Mr. Cooke: In the mean time maybe the Parliamentary Assistant can express our desire that he might want to try to change his schedule to be here tomorrow at ten?

Ms. Hart: I understand that that is not possible, but I will do my best to get him here, too.

Mr. Andrewes: I think the point was made by Mr. Cooke and I don't, believe me, do not do this in any way to downplay the importance of Ms. Hart's role in this committee; simply that I think that at the outset the Minister's attention to this committee on these amendments is something that I regard as having some importance.

The Chairman: It is traditional for major legislation for the Minister to try to be there for at least an opening statement and for parts of it. Perhaps tomorrow we can will be able, as I say, ascertain when he will be available and try to arrange our scheduling so that you feel you have got an appropriate chance to have major discussion with him.

Anything further?

Now, we will adjourn until tomorrow at 10:00 a.m.

The Committee adjourned at 3:29 p.m.

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STANDING COMMITTEE ON SOCIAL DEVELOPMENT

NURSING HOMES AMENDMENT ACT

HEALTH FACILITIES SPECIAL ORDERS AMENDMENT ACT

WEDNESDAY, FEBRUARY 18, 1987

Morning Sitting



STANDING COMMITTEE ON SOCIAL DEVELOPMENT

CHAIRMAN: Johnston, R. F. (Scarborough West NDP)

VICE-CHAIRMAN: Allen, R. (Hamilton West NDP)

Andrewes, P. W. (Lincoln PC)

Baetz, R. C. (Ottawa West PC)

Callahan, R. V. (Brampton L)

Cooke, D. S. (Windsor-Riverside NDP)

Cordiano, J. (Downsview L)

Cousens, W. D. (York Centre PC)

Hart, C. E. (York East L)

Jackson, C. (Burlington South PC)

Reycraft, D. R. (Middlesex L)

Substitutions:

Davis, W. C. (Scarborough Centre PC) for Mr. Cousens

Newman, B. (Windsor-Walkerville L) for Mr. Callahan

Also taking part:

Hart, C. E., Parliamentary Assistant to the Minister of Health
(York East L)

Clerk: Carrozza, F.

Witnesses:

From the Ministry of Health:

Johnson, J. M., Director, Legal Services Branch

Sapsford, R. T., Director, Nursing Homes Branch

From the Ontario Nurses' Association:

Lynn, G., President

Cole-Slaterry, G., Chief Executive Officer

Babad, A., Nursing Practices Officer

LEGISLATIVE ASSEMBLY OF ONTARIO
STANDING COMMITTEE ON SOCIAL DEVELOPMENT
Wednesday, February 18, 1987.

The Committee met at 10:10 a.m. in Room 2.

MR. CHAIRMAN: Come to order.

I welcome members to the discussions of Bills 176 and 177 that are before us for public hearings, and then for clause by clause.

However, we are starting off the morning, as by agreement yesterday, with a discussion of the recent events at Country Place Nursing Home, and with regrets from the Minister, who's not able to be here today, but can be here tomorrow afternoon.

I have talked to the two critics and suggested that if, after this hour's session, before we get our first deputant this morning, that if they would like more time tomorrow afternoon, I would like to know at about 11:00 o'clock so that we can ask Concerned Friends to postpone to another time so that tomorrow afternoon might be devoted to further interaction by the Minister. And I will leave that up to you to let me know by 11:00 o'clock.

Parliamentary Assistant, would you like to lead us through the discussion on Country Place?

MS HART: Thank you, Mr. Chairman.

First, perhaps I could introduce on my immediate left Ronald Sapsford, who is the Director of Nursing Homes Branch, Institutional Health, from the Ministry of Health. And to my far left, Jack Johnson, who is the Director of the Legal Services Branch of the Ministry of Health.

These two gentlemen are the ones who have been most intimately involved with the recent -- well, all of the activity with respect to the Country Place Nursing Home.

As you know, action was taken yesterday. The Minister moved, under the authority of the Health Facilities Special Orders Act, to take control of Country Place Nursing Home. And it is intended that the Ministry will operate the facility for a period of approximately six months, or not to exceed six months, and to revoke the license of the owner, John Fedina.

Since I am very recently to this post, I thought rather than taking over the briefing myself, I would ask Mr. Sapsford to give us the detailed background of what has happened with this nursing home and why these actions were taken at this time.

MR. CHAIRMAN: Mr. Sapsford.

MR. SAPSFORD: Thank you, Mr. Chairman.

Before I discuss the most recent events, Mr. Chairman, I think it's important to set the actions of the Minister this week in context. And I would like to go back a little bit in time to set the context, before I explain the results of the past week.

MS HART: Maybe I could just interrupt for a second. One thing I neglected to say was that we have copies of the Order that the Minister made yesterday and all of the supporting documentation and the facts on which he acted. Perhaps what we could do is have that distributed.

MR. CHAIRMAN: And also, Mr. Sapsford, we are working on a new system in terms of our Hansard capacity today, and although we have the tapes and are being picked up on that, we also have a Court Reporter who would probably be interested in you trying to project as much as you can.

MR. SAPSFORD: Certainly.

As you are aware, the Nursing Homes Branch of the Ministry of Health is responsible for the inspection of nursing homes, at least on an annual basis, to ensure that the regulations and the Statute are being maintained by nursing homes.

As is the case in every system, the results of these inspections vary across the system of nursing homes in the province. Inspectors find from minor to fairly major problems in nursing homes, and even non-compliances with the legislation.

The purpose of this is to achieve compliance, and Nursing Home operators are expected to respond to the recommendations of the Ministry to inspection reports. The response, when accepted by the Ministry, forms part of the public inspection report that is currently posted in each Nursing Home in the province.

Between last May and July, 1986, Ministry inspector did the annual inspection of the Country Place Nursing Home. In reviewing the results of this inspection, it was apparent that there were many major problems, not only with the physical plant, the general state of repair, but also significant problems with environmental, fire, nutrition, and nursing care.

At that point, an evaluation of the inspection was done, and it was compared with past inspection reports and the past history of the operation of the home. And in

August of 1986, I decided to propose to revoke the license of the Country Place Nursing Home under the authority of the Nursing Homes Act.

According to the statute, a licensee of a nursing home is entitled to an appeal, and the nursing home licensee appealed to the Nursing Homes Review Board for a hearing.

The Nursing Homes Review Board met in the early fall, late September, early October, to hear preliminary arguments. And as is the case under the statute, the Nursing Home Review Board ordered that the licensee be given time to comply with the violations of the regulation, as had been outlined by the Ministry.

The precise date escapes me; it was late September, early October, last week of September, first week of October.

The Board decided to set a hearing date to hear the content of the argument toward the end of January, early February, 1987, a period of approximately three months. The Board also stated that it would take into consideration the degree of compliance achieved by the licensee in their evaluation of the submission.

Between the first date of the Board and the second date of the Board, the Ministry, the Nursing Homes Branch, continued routine inspections of the home, to monitor the care of the home, and to provide information to the licensee on the degree of compliance achieved. This was for the information of the licensee as well as to assist the Nursing Homes Review Board in evaluating the degree of compliance reached.

Inspectors at times were in the home on a daily basis. This could be either a nurse inspector, a fire safety inspector, an environmental inspector, or a nutritional care inspector. Occasionally, they were together. They were in the home on days, in the evening, at night time, and week ends.

During January, the Ministry secured the services of an external professional nurse, who was appointed Inspector under the Nursing Homes Act, to go in and do an external professional assessment of the care of the home. Her report was received by the Ministry early in February of 1987.

On February 3rd, '87 the Nursing Homes Review Board met to hear preliminary legal arguments by counsel of the Ministry and counsel of the licensee. The Board, on hearing the arguments, set a date to hear the evidence of the Ministry, set to be March the 30th, 1987.

During the early days of February, as I have mentioned, the Ministry received the report and a letter from the external evaluator, and that letter is appended to the Minister's order.

During the early parts of February, other significant problems started to show up in the home. Of principal concern was the heat in the building. Inspectors monitored temperatures as low as nine degrees celsius in parts of the building, and in resident care areas, in the area of 15, 16 and 17 degrees, which is well below the standard as defined in the Regulation.

Inspectors found snow coming through windows. Inspectors found people not being fed appropriately and full trays of food returning to the kitchen. Pipes, or a pipe had burst and was leaking into resident care areas.

Coupled with this information on recent inspections, together with the general condition of the building, as had been already reported under the first appeal, or the first Order of Revocation, the Minister decided to move under the Health Facilities Special Orders Act.

On Monday afternoon of this week, Ministry staff appeared at the home and delivered the Minister's Order of Revocation and suspension of the license, and staff at the Ministry of Health are now operating the Country Place Nursing Home.

We have secured the services of the suppliers of the home. We have had meetings with the staff and with family. We have had meetings with union representatives. And we have started to talk on an individual basis with residents.

We have started to increase the nursing staffing in the home, the housekeeping staffing, laundry staffing. We have secured additional resources to begin a general clean up of the home.

We have contacted a heating specialist to come in and do an assessment of the heating, and approximately thirty-six hours, nearly forty-eight hours later, I am happy to say that the residents are calm.

I have had a successful meeting with family members last night, and as far as I can report to the committee at this particular time, the residents are being maintained, and we will make every effort to improve the circumstances in the home in as short a period as possible.

MR. CHAIRMAN: Thank you.
Questions. Mr. Cooke?

MR. COOKE: Thank you, Mr. Chairman.

One preliminary question: What was the response of the Minister of the request from Mr. Fedina to have a press conference at his home today, to take press for a tour through his home, as reported in this morning's paper? But also I heard about this request yesterday.

MR. SAPSFORD: Well, I can't speak to the ---

MR. COOKE: As far as you know, there is not a press conference that is going to go on at that nursing home and disrupt the residents of that home today?

MR. SAPSFORD: Being the Minister's designated representative in the operation of this home, it's my position that television cameras will not be allowed into the home. We have taken the position that the privacy of the residents is our paramount concern, privacy of families.

We have tried to co-operate with the press in giving them information. The designated administrator of the home has met with certain members of the press outside the facility. We are trying to provide information through the Communications Branch, but we are not prepared to let the press into the home to film people.

I might add that when the reporting took place on Monday night, the very next day we received calls from irate family members suggesting that there was no way they wanted to have their relatives shown on the television.

And that's the position we have been taking to this point.

MR. COOKE: Mr. Chairman, when first hearing about this, I felt that my predecessor and Mr. McClellan, who first raised this matter in the Legislature, I think in 1983, this nursing home, the Concerned Friends group, which first wrote to the Minister in 1983 with the same concerns that have now resulted in the take-over of this nursing home, and the staff who were harrassed and fired by the owner of this Nursing Home and subsequently reinstated after an arbitration hearing, with exactly the same kinds of concerns that have resulted in the takeover, have all been vindicated.

My concern is that it took four years to take action to protect the residents of this Nursing Home, and after -- and I have got the inspection reports for the last three years here, and if you go through them, there are problems with cleanliness of the home, problems with the temperature of the food, the quality of the food.

The Parliamentary Assistant will not have been a member of the Legislature when the first question raised about this home I remember of was when this home was using a golf cart, an open golf cart, to bring its food from a rest home, which is down the hill, up the hill, and by the time it got there, as reported in a letter that my leader wrote on February 8th, 1984, to then Minister Keith Norton, was that the food was cold and it was taking over an hour to serve the residents. Staffing levels were inadequate; there were odours and dirt in this Nursing Home.

My question is -- well, my comment first is that this is not a demonstration of how well the regulatory process works. This is a demonstration of the absolute and complete failure of the regulatory approach to nursing homes in this province by both the former government, and quite frankly, by this government to this date.

I would like to ask the Parliamentary Assistant, and perhaps ask the representatives from the Minister here today, why is it that it took four years when there were charges against this Nursing Home and the same types of concerns that you have mentioned today?

Why did it take four years to take over this home and protect the residents? And what, under the new legislation that we are considering over the next few weeks, what changes are there in the proposed legislation that will not allow this to happen again?

It's my opinion that there is nothing in this new Nursing Home Act that will prevent this from happening again, but perhaps you can enlighten me in a different direction.

MR. CHAIRMAN: Ms. Hart?

MS HART: Mr. Cook, your question has a number of parts, and I think perhaps Mr. Johnson can also deal with some of them, as his Branch was involved in the prosecutions. In fact, maybe we could even start there.

MR. CHAIRMAN: It's understood some of these things are policy questions and others are drafting, et cetera.

So limit yourself, for your own protection, to matters that are the civil service responsibility.

MR. JOHNSON: Yes.

Well, I can't answer the question of the length of time. I can only speak for the period of time that we have been involved with this particular Branch of the Ministry.

The procedures on inspection, the focus of

inspection, is to achieve compliance. Inspectors act in a way and leave recommendations with nursing homes to bring the standards not only to minimum, but to make improvements beyond the minimum.

There are many homes in the province that provide service beyond minimum. Where we encounter homes that provide less than minimum, which is defined in the Regulation, we begin to gather evidence.

There are three basic avenues available to the Ministry to achieve compliance -- shall I say four: the act of cooperation of the licensee in the administration of the home, and by and large that is the major way that we do it;

The second avenue is prosecution, more difficult.

The third avenue is proposal to revoke the license under the Nursing Homes Act.

And the fourth level, revocation of the license under the Health Facilities Special Orders Act, which includes the power of the Minister to suspend the license immediately.

MR. COOKE: Can I just interrupt for one second?

All three avenues to achieve compliance have been attempted with this home in 1984, '85 and '86. Annual inspection reports would demonstrate that there were nineteen violations in the annual inspection report in October of 1985, 39 in 1984, and 30 in 1983.

Violations in October of '85, which is the point at which this party was government: Residents call-systems were not operational; no activities for dependent residents; mould growth and dirt in the fridge and freezer; walls and floors throughout, dirty, sticky; urine odours; mill areas not cleaned; spills from breakfast still there at lunch time; dried food on clean dishes; snacks not being served; therapeutic meals not being served. That was in October of 1985.

So obviously, through the annual inspection process, compliance orders were written and that didn't work.

There were charges laid against this home. In 1984, there were fourteen charges laid against Country Place. They resulted in five convictions with fines of \$1,000 each. In 1983, there were three charges. One was withdrawn and there were two convictions, one suspended sentence, for \$200.

The point being that both of the other avenues were

attempted as far back as 1983 and it didn't work. And now we are at 1987 before we take the final step of revocation of the license.

What went wrong? Why did it take four years?

MR. SAPSFORD: Well, since the inspection in 1986, which was the follow-up to the report you referred to in October of '85, action was taken under the Nursing Homes Act, as I have outlined.

In the experience of the Ministry, when we proceed either to prosecution or to propose to revoke, it's my view that we have to proceed in a measured and fair way.

The legislation which I work with currently has due process involved. Licensees have right of appeal. And given these circumstances of the legislation, in my view, the Ministry has to in a measured way build a case. Because when we take the step of proposing to revoke, we want to be assured that the Board is in agreement with the Ministry.

MR. COOKE: That gets down to the bottom line question, the approach of the Ministry -- and perhaps this is a policy question -- the approach of the Ministry that is being proposed under this legislation and under Bill 177, which there is amendment to, continues to rely on this philosophy that nursing homes be given repeated opportunities to comply with the Act.

And I would like to know how on earth another situation like Country Place could possibly be avoided when the philosophy of this Act is exactly the philosophy of the old Act, and we are going to give nursing homes opportunity after opportunity to comply with the Act, which could mean that there could be many other Country Place Nursing Homes that could take years to finally see residents protected.

And I would daresay that over the four years, a great number of residents at Country Place Nursing Home died -- I am not suggesting that it's as a direct result of the violations of the Act -- but I am saying that they will never see any action to improve their home being implemented by this Ministry, when it takes four years.

MR. CHAIRMAN: Miss Hart.

MS HART: If I might, Mr. Chairman, I take issue with you somewhat in that these amendments certainly improve the ability to gather evidence, the kind of evidence that can be gathered by inspectors....

MR. COOKE: What section of the Act refers to that?

MS HART: I do not have the sections of the Act in front of me. I will get those to you.

MR. COOKE: I suggest there isn't one.

MS HART: Oh. There is, certainly.

MR. COOKE: On inspections?

MS HART: You can take -- yes. They can take copies; they can take tests. They can -- it's in that segment of the Act dealing with inspection.

There is also the ability to take commissioned evidence from residents of the home, which was not there previously, and always causes difficulties when you are talking about infirm people.

There is currently a reorganization, as I understand it, of the Nursing Homes Branch that is separating the compliance section from the enforcement section -- inspectors is what I was thinking about -- and that is also a step that separates the two functions under the Act.

And the whole role of legislation of the government in this area is to strike the balance.

You have to look at the purpose of the legislation. Are we passing legislation in order to bring retribution against Nursing Home owners, or are we engaging in a balanced attempt to provide the best homes we can for our seniors to balance their wishes -- because even in this case, there is a petition by a number of the residents and their families, not wishing the license to be revoked -- to balance that against making sure that the home that they live in is up to standards that we have set for this type of home.

MR. COOKE: This is the section I am referring to: An act to amend the Health Facilities Special Orders Act. Section 10, and they are adding the following subsection: opportunity to comply:

Before the Board hears a matter, it must be satisfied that the licensee has been given a reasonable opportunity to comply with all lawful requirements for the retention of the license where it would be just and reasonable to do so.

MS HART: That is exactly what I was referring to.

MR. COOKE: That is a retention of the philosophy that has gotten us into trouble with Country Place.

I mean, if a simple violation of the Highway Traffic Act occurred, and if you are speeding on the 401 and the police officer pulls you over, he doesn't say, "We are going to give you an opportunity to comply with the speeding laws of this province."

MS HART: And he doesn't remove your license either.

MR. COOKE: Well, you get a ticket. You get fined.

MS HART: You get several chances.

MR. COOKE: You get fined. And the system of implementing the Nursing Home Act in this province, you get opportunity after opportunity to comply with the Act before you even get charged under the Nursing Home Act, let alone have your license removed.

MS HART: Well, we have a difference of philosophy, obviously. I don't view the legislation as retribution. And I think what we are trying to do in a cooperative effort is to make these homes work.

If you look at those infractions ---

MR. COOKE: If you had been here longer, Miss Hart, you might understand that that's been tried and it doesn't work.

MS HART: -- many of them are very, very minor infractions. Some of them are dietary infractions. Some of them are environmental infractions.

Any one of them by themselves is probably not enough to justify revocation. It's taken together.

MR. COOKE: I'm talking about even fines. Nursing homes are given regular and ongoing opportunities to comply with the Act before they are even charged under the Act, let alone have their license revoked.

MS HART: Perhaps Mr. Johnson would like to respond.

MR. JOHNSON: If I could, sir, address the question that you referred to, and there is a precise counterpart, as you noticed, in the Nursing Homes Act itself.

What that section tried to do is to avoid a problem we have encountered in Country Place, which is that before taking the revocation proceedings, one goes through a stage of inspecting, warning, trying to get compliance, and finally one takes revocation proceedings.

So there has been an opportunity to comply in that sense.

The way this legislation reads at present, we then launch the revocation proceeding and the Board immediately says "Ah, there must be a period to comply."

And essentially we launched our revocation proceeding August 15th, and we see it coming to a final hearing March 30th of this year. This section is trying to eliminate that double period.

So that if we go before the Board and say, "Look, these people have had six months of warnings, inspections, and so on." We hope to be able to persuade the Board to move immediately to a revocation hearing instead of giving them another three or four months. That's the purpose of those two sections.

MR. COOKE: But I am wondering why there is even a philosophy of why a nursing home would be given ongoing opportunities to comply with the Act, if they are breaking the law. Why are they not then treated as people breaking the law, especially with the extremely vulnerable people like residents of nursing homes?

Why do we have this philosophy of giving people ongoing and continuing opportunities to comply with the Act? What does that serve, other than the bottom line, being that when you are given these ongoing opportunities to comply with the Act, if for example on a simple one, if you cut back on staff and you don't meet the staffing requirements, you have saved an awful lot of money.

So then you get a Compliance Order written and you continue to break the law and you don't come up to the proper staffing levels. Then you might get a charge laid against you and you might get a fine of \$200 or \$250, or even \$1,000. But even so, you have saved all that money over the period of time. So that it pays you to break the law.

That's the problem when you give these nursing homes the opportunity, ongoing opportunity, in this case over a period of four years. They have saved a mint by breaking the law.

MS HART: They haven't saved any at the moment because they've been taken over. It's at the end of the process. Are you suggesting that the nursing home owner should not have the right to appeal or the right to due process?

MR. COOKE: I don't think it's registering with you, Miss Hart. That's not the point. It's taken four years. It's taken four years to get to this point. There has been a lot of money saved over the four years by breaking the staffing regulations, food regulations, heating

regulations, everything that they have done, not keeping the home clean. It takes money to keep a nursing home clean. They have obviously not spent that money.

MS. HART: I guess we just don't view the problem quite as simply as you do.

MR. COOKE: No, we don't. We don't agree on the problem at all. Your philosophy as enunciated in your amendments won't do a bit to improve the nursing home system in this province because of the philosophy that you have.

You can have the best law in the whole world for nursing homes, but as long as you continue to enunciate that philosophy, nothing is going to change for the nursing home residents of this province.

THE CHAIRMAN: Mr. Reycraft.

MR. REYCRRAFT: Mr. Chairman, I seek some advice from you on procedure. I am not clear on what the objective of what we are doing this morning is.

My understanding is that the standing committee is charged with the responsibility of holding some hearings on a couple of Bills that deal with nursing homes, and then dealing with the Bills.

Now, I heard Mr. Cooke yesterday ask for some information to be presented at the committee this morning related to the issue that's been under discussion.

How long do you intend to have us discuss the matter?

I guess the first question should be: Is it appropriate for us to enter into discussion and debate on this issue in this forum, and if it is, how long do you expect us to continue that?

THE CHAIRMAN: You decided it was yesterday or you would have told me otherwise, and ---

MR. COOKE: Mr. Chairman, I am completed, although I would suggest that it might be appropriate for this committee at some point to consider a Motion to the Minister that could be communicated in the form of a letter, that I think that this would be a perfect example, this nursing home, where perhaps a public inquiry, or some form of a review of what happened over four years, to demonstrate to the public how inadequate the process is would be useful for both government and members of the legislature and members of the public.

MR. CHAIRMAN: Coming back to the point of order

that has been raised, there is obviously a connection between the Bills that we are dealing with and what has taken place. The committee decided it would like to hear this morning about that. Some of the discussion has actually been based around what are the changes in the legislation that would make this different, or whatever, in the future.

And therefore, I could presume this kind of commentary would continue during our hearings, and maybe from deputations, and maybe from members of the committee. So in that sense it's in order.

Our proposal this morning was to try to deal with this matter plus the opening statement by Miss Hart by 11:00 o'clock. So that we could hear from our first deputant this morning, the Nurses Association, which has other commitments and can't come back this afternoon. So we have some time constraints for them.

The Minister we had hoped might be available today to both discuss opening remarks and anything further following from this, I presume, from what people are saying. He is now available tomorrow.

And what I asked for, before you came in this morning, was to have some idea, before we called our first deputant this morning, as to whether or not you wished the Minister to have the full afternoon tomorrow on the Bills, and whatever, and you can decide that before me, or whether you would like to have that time shared with Concerned Friends who are presently booked from 2:00 to 4:00.

So at 11:00 o'clock, or at the point where Miss Hart is finished her opening statement, I will then ask for direction from you on that, and we'll arrange tomorrow accordingly.

Are there other matters on this? Mr. Andrewes?

MR. ANDREWES: I just wanted to pursue some information, if I might, Mr. Chairman. I think that's the purpose of the briefing.

I ask Mr. Sapsford: Mr. Fiden, does he operate other facilities?

MR. SAPSFORD. No.

MR. ANDREWES: The arrangement whereby he was bringing food from a rest home to the nursing home; was that just an arrangement he had with some other operator?

MR. SAPSFORD: No. The licensee owns essentially two separated facilities on the same piece of property.

They are separated by some, oh, perhaps hundred yards. The retirement facility is at the front of the property, and the nursing home building proper is towards the back of the property. And the kitchen that serves the two facilities is located in the retirement home.

MR. ANDREWES: So it's a common facility?

MR. SAPSFORD: Yes.

MR. ANDREWES: When the kitchen is located off premises, does it come under the same restrictions and guidelines as it would if it were located on the premises?

MR. SAPSFORD: Yes. We define the kitchen as part of the licensed nursing home.

MR. ANDREWES: And the kitchen undergoes the same type of inspection, regardless of where it is located?

MR. SAPSFORD: Yes.

MR. ANDREWES: When you talk about compliance, what do you mean by "compliance"? Are you talking about partial compliance, complete compliance? What sort of punitive action is taken if, in fact, a Compliance Order is not met?

MR. SAPSFORD: It depends upon what particular part of care we are talking about.

To give one example, there is a regulation that requires signatures on medical records for various and sundry things. Inspectors routinely inspect medical records to ensure that there is consistency in the way signatures have been put on the record. And where we find errors in that, or omissions or missing signatures, we will issue non compliance with the Act, because the Regulation is clear.

However, the degree of severity of that kind of a problem is not the same as if there were a major violation of the fire safety rules.

So the Ministry views -- there is a certain amount of judgment put on the degree of severity as it relates to health and safety of residents. And therefore, on finding missing signatures on the first occasion, the Ministry would not contemplate prosecution, but rather what procedures you have in place to ensure that signatures of required people are put to the record.

In the course, in a hundred bed nursing home in the course of a year, hundreds of thousands of signatures are required. We check a sample of charts to see that by and large those procedures are followed.

In some of our fire safety violations, we immediately move to prosecution: fire safety doors, problems with fire separations, and so on. We would move immediately.

Where we find repeated problems over a period of time, if signatures on records are not there, then it speaks of the fact that the policy is not there or the staff are not instructed properly, and hence, for repeated problems, we would then proceed to prosecution.

It is not any single thing which would move us into more severe action, such as proposal to revocation, but a collection of factors based on the regulation: What the problem is, what the response of the licensee has been. We expect them to submit a plan of correction, because they are the operators of the facility, not the Ministry of Health.

And so where we issue orders of non compliance, we expect the operator to propose an acceptable plan to correct the problem.

MR. ANDREWES: You indicated where there are safety violations you would move directly to prosecution. Have there been prosecutions of Mr. Fedina over the past three or four years?

MR. SAPSFORD: Yes.

MR. ANDREWES: How many?

MR. SAPSFORD: In 1983 and 1984, there were either four or five in each case.

MR. ANDREWES: In each case?

MR. SAPSFORD: Yes.

MR. ANDREWES: All successful?

MR. SAPSFORD: I believe all but one.

MR. ANDREWES: And what would you say of the relationship between Mr. Fedina and the Ministry, the historic relationship between this operator and the Ministry? Has it been -- well, obviously it hasn't been rosy. It hasn't been cheerful. Has he been belligerent? Has he been cooperative in some degree or no degree at all?

MR. SAPSFORD: No, he has not been belligerent, to my knowledge. I personally have had very little contact with him. And I don't believe my inspectors have had very much contact.

Our problem has been in getting acceptable plans of compliance and continued problems on inspection.

MR. ANDREWES: And what of the relationship between Mr. Fedina and his staff?

MR. SAPSFORD: I have no assessment of that.

MR. ANDREWES: None at all?

MR. SAPSFORD: The direct relationship; no I can't speak to that. I know there have been problems in the home in some cases of staff getting acceptable supplies, or problems receiving it.

In the inspection report last July, one of the major problems was adequate nursing equipment, dressing trays. Now, that was not for want of staff requesting, but rather not receiving.

So one can use that as an indication.

THE CHAIRMAN: Did you have something, Mr. Baetz?

MR. BAETZ: Yes.

We have heard of your relationship with Mr. Fedina since '83, I guess. What is his long track record? When did he start up this nursing home, how many years ago? Has it only been there for four or five years?

MR. SAPSFORD: No. I can't answer the specific date. He's been, I believe, in operation for 15, 16, 17 years.

MR. BAETZ: For 15 or 16 or 17 years. Then surely somebody in the Ministry of Health would have some kind of a record of what kind of an operator he has been over the 15 or 16 years. Has something gone wrong with ---

MR. NEWMAN: (Inaudible)

MR. BAETZ: No, but I would be very interested to know. For 15 years; maybe there was no trouble for the first ten. Maybe something happened to him personally. I don't know. But I think it would be very interesting to know just what this man's life long track record is, as far as operating nursing homes is concerned.

THE CHAIRMAN: Why don't we try to get some documentation, perhaps if you've got it within the Ministry, for the period prior to 1983, I guess was the earliest information you received, and have that tabled with the committee?

MR. BAETZ: I would like to have that, yes.

MR. COOKE: Could we get the financial records that were filed with the Minister prior to 1979 on this, as well as the inspection reports?

MR. SAPSFORD: I frankly don't know. I will find out.

MR. COOKE: Okay:

MR. BAETZ: I mean, if we can get that, that too would add to it. Because I don't want to impune motives to Mr. Fedina, as maybe Mr. Cooke has suggested.

I mean, I think you made the statement that he cut corners because he knew the fine would be less than the cost of providing the service. That to me suggests that Mr. Fedina sold more than all of us was making profit. Maybe that was the case.

Or maybe it was simply a man losing interest in this nursing home and he's operating other ventures, maybe outside the nursing home field. Maybe he is incompetent. Maybe he's a sloppy administrator. I don't know.

I think it would be rather interesting though to get a little more insight and a little more information as to what kind of a person, what kind of an administrator we are dealing with here.

MR. CHAIRMAN: Perhaps we could have a report by tomorrow in terms of what's available, or what's possible, and then table it as soon as you can, whenever that is. Would that be possible?

We should know what the limitations are going to be quickly, and then if you can provide us with the information of whatever is possible, that would be good.

MS HART: Can I put this caveat on it? I understand that there may be a lawsuit against the Ministry, and I would like to consider this question and see if we are going to bring ourselves into real difficulties if we release documentation that is not public documents.

MR. COOKE: Inspection reports are public documents; financial documents we obviously think should be public or they wouldn't be part of the new amendments.

MS HART: I just ask for overnight to consider that.

THE CHAIRMAN: If you can report tomorrow on what you think is possible, that would be great, and then file

with us at the earliest opportunity after that.

Mr. Jackson?

MR. JACKSON: Thank you, Mr. Chairman. I have a short question:

It's my understanding that there was an identified period of non-compliance with certain regulations, and that there was an attempt to bring the operator into court, and that at some point the Ministry or the Ministry Legal Staff did not attend.

Is there anything in your understanding of this case that has to do with the Ministry not being able to fulfill the objectives of the Act by virtue of not being able to attend a certain court hearing, or was there some process slip here?

MS HART: Yes, there was, and perhaps we could ask Mr. Johnson to speak to that.

THE CHAIRMAN: Mr. Johnson?

MR. JOHNSON: The charges in question, there were four charges relating to keeping the place in a sanitary condition, keeping the kitchen sanitary and having a qualified kitchen overseer.

These charges were laid in January of 1986, and they were not taken to trial because of a case that I am sure everybody has heard about, the Elm Tree case, in which the High Court cast doubt on the enforceability of some of our regulations.

So these charges were among many charges which were, I guess, adjourned from time to time while we awaited the Court of Appeal decision. We are still waiting for that. The case has been heard. I would assume we'll hear in the next few months.

Okay. One, if you will, of the routine adjournment dates was January 23rd of 1987 when our prosecutor should have been there simply to speak to putting it over to a new date, because we are still waiting for that decision.

The member of my staff failed to appear, and as I understand it, the Presiding Judge did what he is entitled to do, which was dismiss the charges for want of prosecution.

That is an error in my Branch and one that I have to deal with.

MR. JACKSON: My question of Miss Hart then is: Have you undertaken, or are you about to undertake any

investigation of those circumstances as were just set out to us?

MS HART: It has just been stated to you that it was an error. We don't contest that it was not in error. Too many negatives perhaps, but....

MR. JACKSON: That wasn't my question. Let me ask you again:

So then you are not conducting any investigation to determine -- I think one of the reports I read was that the individual in question was having some personal and emotional difficulty; that was their reason for non-attendance that day in court.

I mean, are you satisfied that the level of service and supervision in that very highly sensitive area of responsibility within your Minister's Ministry is being adequately conducted?

MS HART: I think we have an investigation when you have a concern about whether or not something was indeed an error. When it's an admitted error, there is no reason to pursue it further.

MR. JACKSON: Okay.

Perhaps your private sector experience prevents you from, or your limited private sector experiences prevent you from pursuing a matter not in the interests of punishing anybody, but perhaps to ensure that this doesn't happen again.

I just find it highly unusual that a man, such a highly publicized case, where this difficulty occurred and where it may occur again.

MS HART: That's right.

MR. JACKSON: The error happened; we acknowledge that. To what extent are you working to ensure that it doesn't happen again and what procedures have you put in place?

I mean, there was an obvious assumption that someone was going to do their job. This was a relatively mild case, as I understand it, relative to some of the cases the Ministry might be prosecuting under.

MS HART: I would like to deal with that first before I refer it to Mr. Johnson.

Your question did not relate to whether or not it would happen again. I will ask Mr. Johnson to deal with

that. Of course, steps have been taken in that regard.

Your question had to do with an investigation. No, there was no formal investigation, and none was thought to be needed because the error was admitted.

Perhaps Mr. Johnson will deal with this.

MR. JOHNSON: I was just going to add, sir, that obviously there was a fault there that occurred in my Branch. I am responsible to assess why it occurred and to take steps to see that it doesn't occur again. I believe that I have done so, and it should not occur again.

MR. JACKSON: That was the answer I was looking for. Thank you.

MR. CHAIRMAN: Thank you, Mr. Jackson.

We are running a little bit behind, but what I'd suggest is that we have the opening remarks now by Miss Hart and then deal with the procedural question that I raised with you earlier, and then we will call our first deputation before us.

MS HART: Mr. Chairman, there was just one further thing I wanted to say about Country Place. There is a hearing by the Nursing Homes Review Board on March 30th when all of these issues will be canvassed, and I think the members might be interested in that.

MR. CHAIRMAN: Thank you. All right.

The opening remarks have been circulated to the members, and we won't dispense with these opening remarks, but we'll allow the Parliamentary Assistant or the Minister -- whoever is before us -- to at least exercise her vocal cords for awhile. Miss Hart.

MS HART: Thank you, Mr. Chairman.

As Parliamentary Assistant to the Minister of Health, I am pleased today to appear before this committee to outline details of the amendments to the Nursing Homes Act.

I would like to offer some general comments on what we would like to achieve with the proposed legislation.

The 1980's will be remembered as the decade that government and society began to change the way they viewed the elderly. We are realizing that most senior citizens are physically and emotionally capable of living full and active lives. Away from many of the responsibilities that occupied them in their younger years, many seniors find

themselves with not fewer lifestyle choices to make, but more.

It is this government's intention to provide those senior citizens with the support and resources they need to make those decisions. And we are already at work.

We were the first government in Canada to appoint a Minister for senior citizen affairs, The Honourable Ron Van Horne, who is now conducting a thorough review of all programmes offered for the elderly in every government ministry.

Today it's time to move forward on another front. It's time to see that those seniors living in Ontario's 330 nursing homes have similar opportunities to make their retirement years ones of quality, decency and vitality. We believe those objectives can be advanced with the proposed amendments to the Nursing Homes Act and the Health Facilities Special Orders Act which this committee will be considering.

We have two basic goals in mind. First, to increase involvement by residents, their families and the community in nursing home life; and second, to clarify and strengthen the role of the Ministry of Health in guarantying quality of life for nursing home residents.

The proposed amendments fall into five broad categories: residents' rights; residents' counsels; quality of nursing home life; ownership; and financial issues.

Residents rights:

The Nursing Homes Amendment Act sets out a basic statement of principles that will govern the operation of Ontario nursing homes. Paramount among these principles is that a nursing home, above all else, is the home of its residents. Residents will have the right to proper food, shelter, clothing and care, the right to communicate in privacy, the right to participate fully in decisions regarding their medical care and treatment, and the right to pursue their social, cultural and other interests.

Every nursing home owner will be required to post this basic statement of principles in the home and give a copy to each resident or their representative.

As well, contracts signed when a resident is admitted to a nursing home will be deemed to include the undertaking that these principles will be the basis upon which the home will be operated.

These principles reflect the fact that it is not

good enough for nursing homes simply to meet their residents' physical needs. Psychological, social and spiritual needs are just as important.

Regulations under the Nursing Homes Act protect residents' specific rights. Penalties for homes failing to comply with these regulations range from fines to revocation of licenses for serious and repeated offences.

Homes may also face civil action if they fail to honor their contracts. In summary, these rights are and will be enforceable.

We are proposing a number of amendments to give residents a stronger voice in the day-to-day management of their homes. We understand that in this area much will be new to residents and their family. That is exactly the point: We are challenging them and their communities to become more involved with the life of the Nursing Home.

It's clear that many Nursing Home residents are ready and willing to respond to that challenge and take an active part in the operation of their homes. Residents councils will be set up at every nursing home where at least three residents or their representatives request one.

Each council can appoint an advisory committee of between three and ten members. Three of those members may be appointed by the minister from the community. The rest will be selected for the residents council.

The committee will be the main vehicle for residents to increase their involvement in the operation of their home. It will meet regularly with the nursing home owner. It will examine Ministry inspection reports, financial statements, and it will review the allocation of money for food, supplies and services.

It will also investigate residents' complaints, revolve disputes, and report to the Minister any concerns or recommendations it has about the operation of the Nursing Home.

The amendments also provide for the appointment of an advisor to assist the committee in its activity. Typically, the advisor will act as a paid agent for several homes. This will facilitate a sharing of experiences and information. Solutions that are developed at one home will be passed on to others.

It is our intention to set up this system of advisors as a program operated by a provincial nonprofit organization. This will give a provincial perspective to residents council activity.

One further amendment in this section grants agents of the residents' council full standing as parties before the Nursing Homes Review Board.

As well, residents or their representatives may make submissions at Board hearings.

In summary, these amendments establishing residents' councils will provide residents, their families and the community with the power to become more involved in the daily life of their Nursing Home.

Quality of life:

Several amendments are proposed to guarantee the quality of life of nursing home residents.

First, the Minister will be authorized to enter into contracts with specific nursing homes to increase services where there is a demonstrated need.

An example of this would be the Ministry funding additional nursing staff or developing new programs for the care of Alzheimer's residents. This arrangement will allow for greater accountability in the funding we provide to nursing homes.

Second, the legislation requires anyone who believes that a resident has been harmed, as a result of unlawful conduct, improper or incompetent care or neglect, to report it to the Ministry's Nursing Home Director.

Anyone reporting such incidents will be protected from reprisal. Nursing Home owners will also be required to forward all written complaints concerning residents' care to the Director.

I want to make it clear that the Ministry will take prompt and appropriate action on every such complaint it receives.

Third, our legislation provides that if a resident is physically unable to appear in court to give evidence, a Justice of the Peace may be appointed by a Provincial Judge to take the evidence from the resident at the Nursing Home.

The same situation would apply to those residents who wish, but are physically unable, to give evidence before the Nursing Homes Review Board.

Home Ownership and Financing:

Changes in ownership and management contracts can affect the daily operation of nursing homes and have a direct affect on their quality of care. Several amendments

expand and strengthen the government's authority to regulate these changes.

First, there will be stricter reporting requirements on shareholder ownership so that the Minister can know not only the officers and directors of a home, but also those with controlling interest. Corporations will be required to notify the Minister about any changes in controlling interests which affect the license.

Second, in approving or refusing a license, the Minister will be able to consider the past conduct of those with controlling interest. Their honesty, integrity, and competence to operate a nursing home will be assessed.

Third, these amendments will allow the Minister to take into account criteria, such as concentration of ownership and the balance between profit and non profit ownership, in considering whether to issue or refuse a license.

Fourth, because a nursing home's financial affairs and quality of care are also linked, we are proposing the following:

That Nursing Home owners provide the Ministry with annual statements of profit and loss for each home; that these financial statements, including detailed expenditures on supplies and services, be posted in each home alongside the Ministry's annual inspection report, that this financial information be presented in a way that is both useful and understandable for the residents and their families.

It will be incumbent on each nursing home owner to provide this information, even if the owner has contracted to have the home managed by a third party.

Other amendments call for increased powers of inspection to allow for the collection of evidence and classification of ownership liability under the Nursing Homes Act.

On that last point, the amended Act will hold the licensee liable for everything that occurs in the home, with the exception of harmful acts inflicted on residents. As well, maximum penalties for violations of the Nursing Homes Act will be increased to \$5,000 for a first offence and to \$10,000 for subsequent offenses.

Mr. Chairman, this is legislation for the 1980s. It was developed after extensive consultation with those in the Ontario Nursing Home industry, and with workers and advocates in the fields. It is intended to proceed in tandem, not only with the work of Mr. Van Horn, whose

activities I described earlier, but also with that of Father Shawn O'Sullivan. Father O'Sullivan is conducting a review of advocacy for vulnerable adults in Ontario and should be reporting back to the Attorney General by June of this year.

We think the 30,000 residents of Ontario nursing homes will be well served by this legislation. I urge members to give it their careful consideration and review. Then let's get to work to ensure that all nursing home residents enjoy days and years filled with comfort, dignity and respect.

MR. CHAIRMAN: Thank you.

There is a question from Mr. Cooke, and I thought that we'd agreed that we were ---

MR. COOKE: I guess it's almost a procedural question, but....

MR. CHAIRMAN: Those are always in order.

MR. COOKE: One observation, that is, Mr. Chairman, to the Parliamentary Assistant:

In your statement, you say this is legislation for the 1980s. I might point out we are almost in the 1990s. But that's typical of how we deal with nursing home legislation.

I am wondering if the Parliamentary Assistant and if the Ministry has any amendments that they already know they are going to be putting to the proposed amendments, and what regulations that will be eventually attached to this legislation are prepared, so that we can properly discuss this legislation over the next couple of weeks.

MS HART: We do not currently have amendments. I anticipate that there will be amendments drafted over the course of the public hearings, and when they are drafted, we would be happy to share them with you.

MR. COOKE: What about all the regulations? There is lots of regulatory power given in this bill.

MS HART: Regulations have not been drafted. It would be a little putting the cart before the horse to draft before you know what the legislation is going to say. We will have ---

MR. COOKE: It's very difficult ---

MS HART: Perhaps you would let me finish my answer: We will have, in the course of clause by clause, a

pretty good indication of what regulations are intended to be drafted.

MR. COOKE: It's very difficult, quite frankly, to deal with this legislation without seeing the regulations, since basically there are large portions of this legislation that simply give the Ministry regulatory making power.

And it's almost impossible to properly judge this legislation without seeing the draft regulations. And it is normal procedure around this place that we are given draft regulations when major pieces of legislation like this are brought forward.

THE CHAIRMAN: Mr. Andrewes.

MR. ANDREWES: I have a question of Miss Hart:

You said that you anticipated some amendments, but you had none at the moment. I guess our experience over the last year-and-a-half has been with these bits of legislation that are source to the Ministry of Health, that we have had expensive amendments introduced by the Ministry itself on a daily basis.

So I want to go on record as supporting Mr. Cooke's question and appeal to you that we need those amendments given to us well in advance so that we can review them.

MS HART: Mr. Andrewes, your point is well taken, and it makes my job a lot easier if they come sooner too. I will do my best to get them to you soonest.

MR. BAETZ: Time will tell.

MR. ANDREWES: Time will tell.

MR. CHAIRMAN: Time will tell, indeed, as it always does.

As a procedural matter, what is your desire for tomorrow afternoon when the Minister can be available to us?

MR. COOKE: Mr. Andrewes spoke to me briefly, and the only thing is that there are a number of questions that come out of the legislation and out of the opening statement that I would like to get clarification on.

Normally, on a major piece of legislation like this, I would like to know, for example, how the residents councils and the residents council advisory, all this stuff is going to work, things that couldn't be answered during the lock up that we had when the legislation was

introduced, and plus some questions that come out of the Country Place situation.

I don't like to bump any one, and I would only want to do it if it would be convenient to Concerned Friends.

MR. CHAIRMAN: Mr. Andrewes?

MR. ANDREWES: Well, the clerk has done a commendable job in scheduling a number of these witnesses, and I find it absolutely astounding that on a major piece of legislation like this that the Minister would not be in attendance at the outset to respond to these questions.

I feel rather strongly, Mr. Chairman, that these groups have been scheduled, we proceed with the schedule, and if the Minister hasn't got the dignity to grace this committee with his presence at the outset, then we'll deal with those matters later.

MR. COOKE: At a minimum we would, if we can't come to an agreement in the committee at the minimum, want to have at least a half a day with the Minister before we get into clause by clause.

MR. CHAIRMAN: I guess my question for you is -- because I don't hear a consensus at the moment -- is that I am presuming that you both do want some time, would prefer some time with the Minister in terms of question and answer, the normal format that would follow an opening statement by the Minister.

If you would like me to -- I understand the desire not to disrupt people who are already on the list, and Concerned Friends especially we have given a whole afternoon to, given the amount of work they have done in this field in the past.

Can I ask the clerk to make an approach to them to see how they would feel about being a later deputant, rather than an early deputant, and if that would bother them, then we will say no, and we won't deal with it? We will have them on tomorrow.

And if they say that that's a problem for them, or that that would help them -- which is a possibility always when somebody's on this early -- that we would find another date for them.

Doing it that way, but making sure that they understand they are under no pressure at all; would that be suitable? I just don't want us to use a lot of time tomorrow afternoon while Concerned Friends are sitting here for a major exchange with the Minister, because I think that would be in some ways less polite to them than giving

them advance notice.

MR. ANDREWES: It would be very wrong to do that. I think at this point in time -- and I don't want to take away from your attempts, Mr. Chairman, to achieve consensus -- my first preference would be to find some other time for the Minister to appear, possibly at the end of the deputation.

My second preference would be to follow your suggestion that perhaps Concerned Friends would appear at the end of the deputations and the Minister could appear tomorrow afternoon. I.... Well, I have stated my preference.

MR. CHAIRMAN: Well, how do you want me to leave this?

MR. COOKE: I like Mr. Andrewes' second preference.

MR. CHAIRMAN: Okay. Why don't -- let's put it this way:

Why don't we just let Concerned Friends know what the discussion has been, and that the preference is not to disrupt them inordinately at all, and to put the emphasis that way and see what their reaction is. And we will either then -- if they say they would prefer a later date, if that would be their preference, then we'll move them, and if they don't, we'll move the Minister to Wednesday afternoon next, which would be the ending of, we presume, the public hearing section of this before we go to clause by clause. Okay? Would that be all right?

Well, let us start our public hearings process then and have the Ontario Nurses Association come forward to make their presentation.

We're going to need at least one extra seat to be moved down.

Welcome. Some of you have been before committee before, so you know how things operate. But essentially the way we will proceed is for you to read your report to us, or summarize it in any way that you would like in as much time as you feel would be convenient for that, and then we'll open up to questions following that but not interrupt the presentation in any way.

But first, if you could introduce yourselves. And I think there are only two mikes there; if you can be sure that you are speaking relatively directly at a microphone in front of you, and not leaning too far back in the chairs, which we all tend to do around here, then we'll be sure we get you for posterity.

So that you could perhaps introduce yourselves.
First let me say welcome.

MS LYNN: I'm Gloria Lynn, President of the Ontario Nurses' Association.

MS BABAD: I'm Marlene Babad, Nursing Practices Officer for the Ontario Nurses' Association.

MS COLE-SLATTERY: I'm not sure I want to be recorded for posterity. I'm Glenna Cole-Slaterry, the C.E.O. of the Ontario Nurses' Association.

MR. CHAIRMAN: It's been done before though.

All right. Please proceed any way you like.

MS LYNN: Mr. Chairman, members of the Social Development Committee, the Ontario Nurses' Association is the union which represents more than forty-five thousand registered and graduate nurses employed in Ontario nursing homes, homes for the aged, hospitals, public health units, V. O. N., medical clinics and industry. O.N.A. represents more than seven hundred and fifty nurses employed in sixty-one nursing homes.

As the voice of these nurses, we welcome this opportunity to express our concerns about Bill 176 to this committee.

I would like to take the opportunity to commend the Minister of Health for the broad consultative approach taken prior to the introduction of this legislation. The union supports the introduction of legislation to improve the care of residents in nursing homes. However, there are several areas of Bill 176 that the Union strongly recommends be changed, and I would like to address them now.

The Legislation includes a number of principles under which nursing homes should operate. However, it does not include a mechanism to ensure enforcement. As you know, there have been several problems with enforcing the Nursing Homes Act in the courts. Legislation must be clear in order to sustain a charge.

O.N.A. recommends a legislative bill of rights to inform and protect both the resident and practitioner. The bill should be developed by a task force of residents, consumer representatives, practitioners and government.

Bill 176 allows the Nursing Homes Review Board to name additional individuals and groups as parties before it. The Union believes that employees and their

representatives should be parties before the Board. Since the Board will be examining residents' care, its findings and decisions could affect individual nurses. Therefore it is essential that the Review Board not have discretionary power in this matter.

We also believe that individual residents and their representatives should be included as parties before the Board. Mr. Chairman, O.N.A. has a number of concerns about the inspection process and believes that several changes must be made to ensure quality care.

We believe that additional money should be made available for hiring more inspectors and for improving the inspection process. For instance, the Ministry should vary its inspection times so that homes are not aware of when they will be inspected.

Also, the Bill should ensure immediate compliance when conditions endanger the residents. Inspectors should be required to talk to residents and employees during an inspection tour.

The Union supports the reporting of resident abuse. We also support the principle that reporters should be protected from discipline, discharge and intimidation.

However, this legislation would only protect the reporter from such action if she did not act maliciously or without reasonable grounds. We are concerned with the application and interpretation of this wording and believe it should be removed from the legislation.

And employer could discipline or discharge an employee and state that the reporting of resident abuse was not based on reasonable grounds. While a hearing might overturn the employer's action, the employee would have to go through a hearing and obtain legal advice and assistance. This process in itself can be intimidating and ultimately defeat the purpose of the legislation.

O.N.A. supports the amendments on disclosure of financial information. However, we believe the wording should be expanded to ensure that information also includes the allocation of money for supplies and services.

While the Union supports the work done by residents councils and the involvement of residents, their representatives and community members in care delivery, we are concerned with the functions and powers of the Residents Counsel Advisory Committee and believe it could delay investigation in handling of complaints.

Instead, O.N.A. believes the Ministry of Health's inspection procedures must be strengthened. We also

recommend the establishment of an independent advocacy system. In our position paper on patient rights, we suggested that one option could be a publicly funded network of advocates that have jurisdiction in all health care situations, including nursing homes, homes for the aged and hospitals.

Mr. Chairman, while speaking generally in support of this Bill, the Union strongly recommends that changes be made in this Bill or incurred regulations in areas such as staffing, in-service training and assessment of competency.

The current Regulation outlines the minimum amount of nursing and personal care to be given to each extended care resident by each staff category. Unfortunately, nursing homes are often staffed at this legislative minimum.

There should be sufficient staff available to meet all the needs of the residents, including physical, psycho-social and their spiritual needs. The Union believes that the minimum number of hours of care must be increased and must reflect the varying needs of residents.

O.N.A. is also concerned that all staff be oriented and qualified to work in the nursing home. Appropriate standards of care should be set and implementation assessed through quality assurance programs.

The regulation currently requires that every nursing home conduct in-service training programs at least once a month. There is no assurance, however, that staff have time to attend these programs.

Also, each staff category has different educational needs, and therefore different in-service programs should be available. Legislation should be introduced to correct these problems.

It is essential that legislation include procedures for assessing the resident's competency. Such procedures could include appropriate assessment and reassessment of the resident. Appropriate restraint policies should be put into place.

While the Union would like to see improvements in the Regulations under the Homes For The Aged and Rest Homes Act, we would refer the committee to its policies on reviews and assessments. These policies consider staffing and types of restraints -- for example, chemical restraints -- must be reassessed after seven days.

Similar procedures should be included in Bill 176 and apply to all restraints, such as physical restraints, chemical and secure areas. The Ontario Nurses Association

believes that funding methods should be re-examined.

A number of residents require more than the extended care allotment of ninety minutes of nursing and personal care each day.

Also the allocation of money within individual nursing homes should be reviewed in order to appropriately determine whether there is sufficient funds available to provide the care needed.

In conclusion, legislation to improve residents' care is long overdue in Ontario. The Union urges the government to move forward quickly with comprehensive measures which will ultimately result in improved quality of life for residents of Ontario's nursing homes.

I thank the committee for its attention, and we would be pleased to answer any questions.

MR. CHAIRMAN: Thank you, Ms Lynn.

Are there questions from members? Mr. Cooke?

MR. COOKE: Thank you, Mr. Chairman,

I would like to ask you: One of the statements you make under the inspection section leaves one with the impression that you, as representatives of people that work in nursing homes, think that your members are usually aware of when inspections are taking place. And that's always disputed by the owners of the nursing homes.

But I would like to get you to expand on that. Are you talking about surprise inspections, the annual inspections, or both?

MS BABAD: We are talking about both. What's happening now -- and our nurses say this both not only for inspection but also for the accreditation procedure -- is that the owners know. It's not that it's announced, certainly not for nursing homes, but they know because the inspector's in the area and it's more economical for him or her to do all the inspections in that area. And there is quite a lot of sprucing of the homes done prior to an inspection.

MR. COOKE: I know one of the difficulties in my home community is that the inspectors come from London and they come to Windsor.

So I think what you are saying is correct, that when the inspectors are in town, word usually gets out, especially if it's an in-depth inspection at one of the nursing homes, the other nursing homes somehow become aware

of it.

I agree with your concern about reporting harm to residents, that unless the words "maliciously and without reasonable ground" is taken out, that that can be manipulated and used to intimidate people from properly reporting.

Could you give me an idea of what kind of in-service training occurs now, both for your full-time staff and your part-time staff, and what the announcement that the Minister made a few months ago, or whenever -- I forget the amount of money -- fifteen, sixteen, whatever millions of dollars it was that were going to be used as incentives to do as number of things, one of which was in-service training, how that's coming along as well?

MS BABAD: We have a lot of problems with in-service education in the nursing homes, because most of it is provided by the nurses for other nursing personnel, such as health care aids. And as we have indicated, one of our concerns is that there be different in-service education programs available for each staff category, because their needs are different.

For instance, the in-service education provided to nurses would certainly be different in most instances than that provided to health care aids.

The other concern, of course, is that they are usually not able to attend because there is very minimal R. N. staff in particular in the agency. So somebody has to stay with the residents and supervise the other nursing personnel.

We have concerns, a number of concerns with the Ministry's recent announcements concerning funding on in-service education. It's "X" number of cents per resident, and I myself don't remember the exact amount off the top of my head.

MR. COOKE: I think Mr. Nightingale was saying five cents per resident.

MS BABAD: I think.... Five, sorry.

One of the problems is that it's only mandatory for full-time nurses, and certainly for O.N.A. nurses, the majority of our nurses employed in nursing homes are part-time. Indeed we only have thirty-seven per cent full-time nurses.

So that's leaving out an awful lot of part-time nurses who probably would be left to staff the floor when the full-time nurses go.

MS COLE-SLATTERY: Arlene, I think there is an additional fact here. And correct me if I'm wrong, but the existing enabling legislation calls for one R.N. per facility?

In the Nursing Home Act now, how many nurses must I employ if I am running a nursing home?

MS BABAD: It depends on the number of residents.

MS COLE-SLATTERY: And one per how many residents?

MS BABAD: It's based on extended care hours, and I'm sorry, I don't remember them off the top of my head. I have got the legislation here.

MR. SAPSFORD: The minimum entry requirement is one-point-five hours of nursing and personal care per day. That is split in a ratio between registered nursing, registered nursing assistant and health care aids.

The ratio, if my memory serves me, I think it's three-quarters of an hour per resident on a weekly basis, and then that would be multiplied by the number of residents in the home to get the appropriate number of registered nursing hours.

MS BABAD: And for intermediate care, if I remember, it's one nursing personnel per twenty, but it's not divided. Like it's nursing ---

MS COLE-SLATTERY: When you are talking about in-service, then you put your finger right onto it. There is a ratio of -- a minimum number of nurses is spelled out someplace.

Where you take an hour and a half a day for the vigorous healthy people in this room, the amount of time you spend brushing your teeth, washing your hands and face, getting yourself dressed, eating three meals a day, having a shower or bath, getting undressed, going back to bed; I would warrant everyone here spends about an hour and a half, if you clocked yourself, and you can all do it for yourself.

So for people who cannot do it for themselves, who have contracted limbs or who are very, very slow and can't eat in a normal fashion, the hour-and-a-half is ridiculous. You can't take care of a healthy person, if you do everything, all of the aids to daily living, activities of daily living have to be provided in lieu of the patient being able to do it themselves.

Then if you have minimum requirements for R.N., and

you have subordinate staff, so to speak -- and by that I mean not necessarily subordinate in the worth of the work, but subordinate in the credentials and skills package that's required to do the work -- and then you put in a caveat on in-service in which you are now staffing everybody at a minimum, there are various and sundry levels of teaching that need to be done.

And in any event, it's not going to be done because no one can do it within minimum staffing and the hour-and-a-half per patient per day. And that's a twenty-four hour day.

I am sure that fifteen minutes at least of that time is spent mostly -- on the night shift, and forty-five minutes on the evening shift getting them ready to bed, so it leaves an hour-and-a-half to get them up and going in the first place.

So when you put all of these things, it sounds wonderful, but it's totally unimplementable in the broader structure.

Quality in-service would upgrade the proficiency of the staff, which would give the residents a better quality of life, depending on what area the staff was supplying. It sounds fine on paper. But the actual fact of the matter is that it's not adequate staffing in some instances. What is there is perhaps not at the level of the patient needs.

The correction in monitoring of the quality of care -- whatever that means -- if it isn't built-in, you are just shelving the elderly, actually. And the in-service is a part that we are keenly interested in, based on what our members tell us, but it has direct bearing on who gets what when, and maybe it's not quite so esoteric as the average person thinks "in-service" is.

MS BABAD: The other problem with the criteria are that there are twelve mandatory, and we have learned that the legislative minimum becomes the fact of life. Six of those are already designated for specific topics, and the other six are at the...I think they call her the Staff Development Coordinator. And our problem with that is that, of course, the staff -- for instance, if the program is for nurses, they should have input into the program.

MR. COOKE: What is the Staff Development Coordinator?

MS BABAD: That's a person that they have to designate. And I don't know because the criteria have just come down, but usually in the institutions it's the nursing management team already there. It's not normally a full-time person in nursing homes.

MR. COOKE: Yes. I would be surprised if it was.

MS BABAD: No, it isn't. It's just that's what they call them in the government criteria.

MR. COOKE: What do you think the practical impact of this legislation is, while we agree there are some positive aspects with financial disclosure, and hopefully conversion of this statement of principles into a real bill of rights, a number of things that you have mentioned and we have too?

But without the addressing of the staffing issue, what is the practical impact for the residents of nursing homes?

MS BABAD: I think, quite frankly, that if the things that we have identified are not improved, particularly staffing, the qualifications of the staff, et cetera, then the Act becomes meaningless, because if you don't have the staff, if you don't have appropriate standards, you can't give the care that's needed.

And when we speak of care, I want to emphasize we are not only talking about the physical needs of the resident, but we are also talking about the psycho-social and spiritual need. And quite frankly lately -- not lately -- but there is unfortunate emphasis on, "well, we've met the physical needs", and sometimes I don't even think they do that. But we are certainly concerned about the ---

MR. COOKE: Would it be helpful to you if there was an amendment in this litigation that when the annual inspection process and then the annual relicensing process took place, that there was an automatic public hearing with a public review of the inspection reports that took place that year, inspection and compliance, and so forth, and everything that took place that year, which gave an opportunity to the employees of the nursing home, the residents of the nursing home, and the relatives and members of the community to have input into that relicensing process?

MS COLE-SLATTERY: Yes.

MS LYNN: With no repercussions to the employees.

MR. COOKE: Exactly.

THE CHAIRMAN: Mr. Andrewes.

MR. ANDREWES: Thank you, Mr. Chairman.

The statement you made relative to the reporting of harm to residents, and you say, "however this amendment protects" -- and my text I think was a bit different. You were elaborating a little bit on some of those comments.

However, this amendment protects the reporter unless the person acts maliciously, maliciously or without reasonable grounds. We are concerned with the application and interpretation of this wording and believe it should be removed from the legislation.

Are you concerned about the wording or the intent of the wording?

MS LYNN: The wording.

MS BABAD: Both. In the sense that you can put wording in a piece of legislation, and we all know how it can be misinterpreted. We are only talking about the wording in quotes, unless the person acts maliciously or without reasonable grounds. We are not talking about removing the section on the reporting of resident abuse.

MR. ANDREWES: Exactly. But do you think it's fair that a person who acts maliciously or without reasonable grounds should be free of any retribution?

MS COLE-SLATTERY: Who can prove it's malicious?

MR. ANDREWES: Well, I am asking your advice, because you are saying it should be removed. You have problems with the words. I am asking your advice on how we alter the words and at least retain the intent.

MS COLE-SLATTERY: Okay. I am thinking as a staff nurse, and I know -- hypothetical thing -- I can see that the patients don't get anything but the minimum. There are numbers of ounces of greens, or whatever, in the current enabling legislation. I know that they get everything bare minimum, but it isn't really what the intent of that legislation was.

And I have complained about the mice in the kitchen. And I have complained about rotating all three shifts in a one scheduled work period.

Bottom line: I am not the employer's favorite employee. I won't win the gold star at Christmas. And in that person's mind, I am an irritant in the building. And I suppose maybe in many persons' minds I am an irritant. But I don't view me as an irritant.

And then one day I see Suzie Q. Smith smack somebody and I go to report it, and I do report it. And the employer says to me, "You're just malicious. You're into

everything. You complain about everything, and now you have this terrible statement that you have made about Suzie Q. Smith."

Suzie Q. Smith and I being the only ones in the room with a comatose patient, Suzie Q. Smith denies it, and I'm probably out of work.

And if I am working in one of these institutions in a remote area, I have a long way to go to find another job. So what am I going to do?

I'm probably not going to begin telling anybody about the bad food in the first place. And for sure I'm not going to tell them about the mice in the kitchen. And we are going to go right down.

And is it worth my while to report abuse to your mother, if it costs me my job? Because it's probably your mother I'm looking after or your aunt or your...somebody.

MR. COOKE: Who determines under this legislation what's "malicious"?

MS COLE-SLATTEY: Yeah, what's "malicious".

MR. ANDREWES: My point is, before we get, you know, completely off the track, my point is, you are concerned about the wording. Are you concerned about saving, protecting people who wish to act maliciously or without reasonable grounds, whatever that means?

MS COLE-SLATTEY: No. No.

We are not looking to punish people who are acting and have the courage of their convictions and are willing to speak the truth as they see it. And without something in between those two extremes, there are lots of women who are going to see many things and not report it.

MS BABAD: That happens frequently in other proceedings as well. Nurses are frequently reported to, for instance, the College of Nurses. And there may not be proper reasoning behind it. You are going to have a problem because it leaves a loophole for people to use. And so it's safer to just leave it out than put this loophole in.

MR. ANDREWES: Put other words in.

MS BABAD: See the other words. And what are the words?

MR. ANDREWES: Well, you know, that's one of the reasons for these public hearings, is to have groups like

yourselves come forward and offer constructive criticism.

I think you've offered a constructive criticism. It's up to us to find the other word. If you've got thoughts in that regard, help me.

MS COLE-SLATTERY: Don't leave home without us.

MR. ANDREWES: If you don't, then we'll attempt to rectify the injustice.

MR. CHAIRMAN: Mr. Jackson?

MR. JACKSON: Thank you, Mr. Chairman.
Just a quick supplementary, Mr. Chairman.

In your experience in the broader medical field, is there an application for this kind of reporting mechanism in any other type of legislation or procedure that you are familiar with that we might go to to determine language change?

MS BABAD: There is the child abuse, of course, and that is not the same as reporting on suspicion. So there is much more leeway.

I think that's the only one other than, of course, those that are -- those that have a responsibility under individual legislation. For instance, Registered Nurses are under the Health Disciplines Act, so they have an obligation to report. But I doubt it if that wording would help you, because it doesn't deal with the "maliciously" or "without reasonable ground". They just have an obligation to report.

MR. JACKSON: We are assuming on that basis that this wording is insufficient, and we are seeking alternative wording. I guess I would like the Ministry staff at least to struggle with that question over the course of the next three weeks, if there is the existence of another procedure, and it may not even be in the medical field. It may be beyond that even. They could check with Labour.

MR. COOKE: Can I be of help?

MR. JACKSON: I don't wish to go off the topic.

MR. COOKE: I was just suggesting something to you.

MR. JACKSON: I am asking for information.

MR. COOKE: You might want to review the discussion that took place around Bill 70 in giving employees the right to refuse. And it was a similar clause in the

original legislation, that you couldn't refuse work that was unsafe if it was a malicious attempt by the employee.

And that was taken out by the all-party committee that studied that legislation, because they thought it would be a dis-incentive to employees to properly exercise their rights under that piece of legislation, which is the same argument here.

MR. CHAIRMAN: We'll take it under advisement, the notion that we should be trying to look at other legislation.

MR. ANDREWES: Thank you.

Section 17 B. E. and F. deals with the residents council advisory committee. We have a similar sense of direction on that.

What is the right mechanism? You have suggested the Inspections Branch, a broader role for inspectors and a more enforceable mechanism. Are there other mechanisms?

MS BABAD: And we've also recommended the establishment of an independent advocacy system. So we see both.

We are not saying, by the way, of course, residents councils should not remain in existence. We are very concerned with the wording of the functions and powers of the residents council advisory, and I think everybody understands our concern because I have been hearing about it.

So basically we believe that there is a role for involvement in the community and, of course, we have made a number of recommendations outside of this, like joint socio-district health councils which deal with all issues of concerns.

But basically we do believe that the inspection process and the independent advocacy system are necessary.

MR. ANDREWES: Tell me this: In terms of the independent advocate and the independent advocacy system, what form, what mechanism for dealing with the problems are you recommending?

For instance, if the advocate's intervention with the Nursing Home operator or through the Inspection Branch does not satisfy the advocate, does not resolve the issue, what forum is there beyond that? What mechanism would you suggest beyond that?

MS COLE-SLATTERY: If you have a patients' bill of

rights with some enforcement...some teeth in it, not just a piece of paper that people can frame, but something that really has legislative powers within it as for redress.

We are not looking to create a whole other...bureaucrats forgive me, but another bureacratic layer as some have done in very involved programs and those other fine things.

If the patient has a good bill of rights that really is just an extension of his right of citizenry in the first place, it's just that it's spelled out because he's old and can't remind you all that there is a charter and other good things that he lives under.

If there is spot inspections, spot inspections and independent inspections made, perhaps through the Ministry, as to the conformities on an ongoing period; if there is a residents advisory council which members of the family, members of the staff -- that could be broken down in percentages, if that would be that advisory council -- I don't think that the recipient of care should be written out of the reporting mechanism.

However, I don't think that that should be the only person responsible for reporting or being involved in this equality measure you are looking at, because we wouldn't be there.

We spoke publicly a couple or three weeks ago. One little old lady was there, and I said, "if these little old ladies and little old men could do everything you wanted them to do, they'd be home stuffing envelopes for Mr. Cooke while their watching their bean soup." You know, they are there because they can't.

MR. ANDREWES: What about Mr. Andrewes?

MS COLE-SLATTERY: Well, you might find a little old lady stuffing envelopes too for you, Mr. Andrewes. You never can tell. I've seen that, from time to time.

MR. CHAIRMAN: We are all in search of volunteers.

MS COLE-SLATTERY: If he wants one, I will find him one.

MR. JACKSON: (Inaudible)

MS COLE-SLATTERY: Well, I've got lots of time.

I guess what I am trying to say is, the best monitoring mechanism is the one that includes the major players, without having any one part of it being totally and solely responsible. I think that it has to be the

patient, the patient's family, certainly the community.

The community...Ontario is so big, if you have a Nursing Home that's a hundred miles away from the person who needs the nursing home, it's like sending your kid away. It's a terrible, terrible rupture in the family, and it's very, very bad for the person who has to go away from friends and neighbors.

I had an experience recently where my mother had to be in longterm care for a number of years, quite a distance away from the trees and the people that would have made her day. So if the nursing homes are in the communities, the community people are the ones that love and care for them the most, and they certainly should be part of the direction of the quality.

MR. CHAIRMAN: Mr. Andrewes?

MR. ANDREWES: Thank you.

Finally, might I come to the issue of funding. You have said:

However, the allocation of monies within individual homes must also be reviewed to determine whether monies available are inadequate to provide appropriate levels of care.

I think that statement implies that the monies are not adequate in some cases.

MS COLE-SLATTERY: We don't think they are.

MR. ANDREWES: And why?

MS COLE-SLATTERY: I don't know. You have only got one pie.

Probably somebody maybe has not asked for a larger piece of it, larger slice of this particular pie.

If you look very, very generally, all of us sitting in this room, if statistics -- all of us sitting in this room, if statistics are to be believed, will probably live to enjoy the benefits of whatever longterm care you folks are going to structure.

MR. ANDREWES: Why do you think we are working so hard?

MS. COLE-SLATTERY: Well, never under-estimate the long range view of a politician.

MR. ANDREWES: But we are going to bring in conflict of interest guidelines that may impinge on our operation.

MS COLE-SLATTERY: Well, you have to do what you have to do.

But the young woman alluded to the 80s. This is probably the one single topic in health care that we all know for sure will be around at least for the next twenty to thirty years and involve us all because we are all living longer. I am not so sure the quality is as good as it was in the past.

But this is a very, very big ball of wax here. You are just touching the tip of the iceberg. If you don't make mechanisms for appropriate folk -- and I am not just saying that the appropriate folk are registered nurses -- although if I felt that I could get you to believe it, I'd say it -- but the fact of the matter is there are lots of people involved in the delivery of care of any kind. And if it is not funded, it's the old story. You get what you pay for. You buy cheap; you get cheap.

And you have now in the province a nursing shortage. I don't think you want to be responsible for the resurrection of Serigam. There has to be teeth in this legislation and there has to be money in this legislation, because the population of Ontario is probably going to use this legislation. And to what degree of success rests a great deal upon how you fund it. You can't have this kind of care for nothing.

MR. ANDREWES: And are you saying that simply, let's say, an increase in the current per diem; is that a sufficient means of resolving the problem?

MS COLE-SLATTERY: Not necessarily, no.

MR. ANDREWES: How do you resolve it?

MS COLE-SLATTERY: Oh well, you are spending money on things you don't need to spend it on and you could spend it on things you do need.

First of all, there is early detection, prevention and referral, which should be done when a patient is in their 50s, or perhaps 60s if they're really -- don't tremble, Gloria. Many of them here are fifty.

You could utilize the public health and community health services for detection and referral. You could expand the home care sector and let people stay at home. And I don't just mean shuffle around until Suzie Q. Smith pops in with the soup. There are lots of ways that you could spend the same amount of money and get a much better

result.

But when you come down to institutionalization, the more beds you have, the more people you are going to have in them. On the other hand, there does come a time when folk cannot be alone twenty-four hours a day without ongoing supervision.

But if you utilize the community and public health resources that you have at your disposal now.... What you are talking about is, what are we going to do with them after we get them in the home?

MR. ANDREWES: Exactly.

MS COLE-SLATTERY: Well, there are lots of ways that you could make them not have to come to the home for awhile, and when they do, be more accepting, need less care, a lot of teaching of the patients.

We can't even teach an Aide to do some things right. How can we teach a patient how to put on their...I don't know, support hose, or whatever, you know, and encourage them to be somewhat independent? There are lots of ways you could spend the money you're spending and get more in return.

MR. ANDREWES: I guess what I invite you to say -- what I was hoping that you were going to say, was that within a given institution, that the funding mechanism that we currently have is not flexible enough to meet the specific needs of specific patients.

MS COLE-SLATTERY: Funding anywhere, whether it's in acute care or longterm care, should be based on the level of the person giving the care matched up against the acuity of the patient's needs.

MR. ANDREWES: Finally got the answer.

MS BABAD: I think one of the things we are saying is that the whole funding method has to be re-examined, both provincially, because quite frankly, the per diem rate based on the 90 minutes for extended care residents is totally illogical. I mean, some residents require two hours, some three. I mean, their needs vary.

And also at the same time, we are quite aware that the allocation of funds within the nursing home also has to be examined to see where exactly the money is going. So we do have some problem with the current funding for nursing homes.

MR. CHAIRMAN: Was there something supplementary, Mr. Andrewes?

MR. ANDREWES: No. I'm finished.

MS HART: Ms Cole-Slattery, might I ask for your reaction to actually Section 13 of the proposed amendments which enables the Minister to contract with the nursing home for specific services, such as additional staffing? This is an approach that's different from the per diem approach that has been used, or is being used currently.

Do you have a reaction to that?

MS COLE-SLATTERY: Oh, sure. If I am a clever administrator, I can plead such a case that you won't be able to, under your definitions, deny me. On the other hand, if I am busy working like a little beaver, I may not have the time to put together such an erudite presentation and I may not have the skills.

I don't think that -- that lends itself to the cleverness of the presenter who contracts with the Ministry.

You know, I have worked in longterm care. If I am a longterm care administrator or head nurse or director of nursing or head staff nurse, if I am going to go around taking care of your mother, I'm not going to have time writing all of these little pieces of paper asking for more money.

MR. ANDREWES: You are saying it's arbitrary.

MS COLE-SLATTERY: Sure. It depends on who comes and presents the case for more money, and if you like me I'll get it, and if you don't, I won't.

MS HART: Might I just follow up on that? You have stated that you don't think the per diem system of funding is the best and ---

MS COLE-SLATTERY: I don't.

MS HART: -- the proposed system in the amendments is a contractual system. Do you have an alternative to suggest?

MS COLE-SLATTERY: Yes, I do. You fund the care based on the level of care needed and the skill of the person doing it.

MS HART: Is that not exactly what a contractual system is?

MS COLE-SLATTERY: It's not what I see a contractual system is. A contractual system is between you and the

administrator. He may not have any idea whatsoever of the level of people he has laying in those beds.

MS HART: Who does?

MS COLE-SLATTERY: I do, and the members that are given those beds, the nurses.

MR. COOKE: Certainly know the nurses if they don't.

MS BABAD: One of the things we have already commented on are the problems with the example that they are using for in-service education. And, of course, they have added in activation and incontinence program. That's the same type of contractual basis.

MS COLE-SLATTERY: We'll contract with you for reality orientation and we'll get a lot of money from you and we'll teach a resident by lemons and vinegar and get them to come back into the "land of the living" with smells. You'll think this is wonderful. In actual fact, I can use two more people to change the linen on nights.

MS HART: Is not the very point that this gives the Ministry, the Minister, some flexibility to determine that there are extra needs and that they can be funded as needed and ---

MS COLE-SLATTERY: And that Minister's determination is going to be based on the fact of what the administrator brings him as needs. The Minister is not going to go around and figure out, "Well, let me see. They need two more ovens in here and probably a new washroom."

What is he going to base his release of funds on? He is going to base it on the information brought to him by the industry, and that is the administrators.

We are telling you, if you are going to have longterm care, you are taking care of little old Canadian citizens that are not sick and not well, and the people who take care of them are the best ones to tell you.

And I'm telling you, if you don't want to take that as a criterion, take the acuity of care based on the level of competency of the person giving that care.

If you want me to do brain surgery, it's going to take me longer to do it than if you got yourself a brain surgeon. However, I would be willing to try.

(Laughter)

Don't knock it. The Egyptians did tree-fining, and what did they know? I'm talking about in the tomb days of Egyptians. So it can be done. If you're interested in

developing your skills, you can do anything!

MR. CHAIRMAN: Parallels to the Legislature and old tombs in Egypt have always struck me as ---

MS COLE-SLATTERY: Well, we can go one farther: Two things you should never see made: sausages and law. And I think that's what we've got going here.

MR. CHAIRMAN: Unfortunately, we see law made a lot around here.

Mr. Baetz?

MR. BAETZ: My colleague, Mr. Andrewes, has already referred to some of the specific questions I had, but it deals with the residents council advisory committee. And I sense, from the very few things you have said, that you have a good deal of heartburn about the residents council and the advisory, and that may be -- and I don't want to put words in your mouth; I don't have to....

MS COLE-SLATTERY: You won't.

MR. BAETZ: ...but that maybe there is a tendency here to see this council as sort of a panacea to correct a lot of the problems with nursing homes today that maybe more money would solve, or something else.

Would you like to expand just a bit on what you see the function and the limitations of these residents councils doing?

MS COLE-SLATTERY: The function of the council is accurate reporting of facts as best they know. The limitations of a council would be the limitations built into the enforcement part of the law.

If I go to him and I complain and I complain and complain, I've got twelve people that'll swear on the Bible that everything I'm telling him is true, and if there is no force of law at his disposal, I just spit to the wind.

If the council isn't comprised of major players, and if wherever they take their observations, whatever they might be, for investigation, then it should be to someone that can then enforce a patient's bill of rights, if indeed what is set forth as statements by major players in the homes is the truth.

That would involve a little, I would assume, investigation as to the merits and the facts by the Ministry, somewhere or another.

MS BABAD: Well, the residents council also might be

discussing concerns. They shouldn't be considered the watch-dog of the concerns. It just won't work.

MR. BAETZ: Okay. Would you just expand on that point. I am inclined to agree with you, as you may have sensed, but just expand your view.

MS COLE-SLATTERY: No, but we wanted to get that on record.

MS BABAD: Really, I think I got that phrase from Mr. Andrewes in Hansard where I use the phrase "watch-dog".

What we are concerned about is that the council starts dealing with complaints, doing investigations and weakening the inspection procedure, and while they might be discussing concerns, and everybody is aware of concerns and they should be addressed and dealt and forwarded, they shouldn't be considered as replacing or as weakening the appropriate inspection procedure.

MR. CHAIRMAN: Further question, Mr. Bates? Anyone else have questions?

If not, thank you very much.

MS COLE-SLATTERY: My pleasure. Thank you.

(Discussion off the record)

MR. CHAIRMAN: We are adjourned until 2:00 approximately.

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STANDING COMMITTEE ON SOCIAL DEVELOPMENT

NURSING HOMES AMENDMENT ACT

HEALTH FACILITIES SPECIAL ORDERS AMENDMENT ACT

WEDNESDAY, FEBRUARY 18, 1987

Afternoon Sitting

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

CHAIRMAN: Johnston, R. F. (Scarborough West NDP)

VICE-CHAIRMAN: Allen, R. (Hamilton West NDP)

Andrewes, P. W. (Lincoln PC)
Baetz, R. C. (Ottawa West PC)
Callahan, R. V. (Brampton L)
Cooke, D. S. (Windsor-Riverside NDP)
Cordiano, J. (Downsview L)
Cousens, W. D. (York Centre PC)
Hart, C. E. (York East L)
Jackson, C. (Burlington South PC)
Reycraft, D. R. (Middlesex L)

Substitutions:

Davis, W. C. (Scarborough Centre PC) for Mr. Cousens

Newman, B. (Windsor-Walkerville L) for Mr. Callahan

Clerk: Carrozza, F.

Witnesses:

From the Ministry of Health:

Hart, C. E., Parliamentary Assistant to the Minister of Health
(York East L)

Johnson, J. M., Director, Legal Services Branch
Sapsford, R. T., Director, Nursing Homes Branch

From the Ontario Nursing Home Association:

Nightingale, H. M., Executive Director
Stevens, D.

LEGISLATIVE ASSEMBLY OF ONTARIO
STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Wednesday, February 18, 1987

The Committee met at 2:00 p.m. in Room 2.

MR. CHAIRMAN: Order.

Public hearings dealing with Bill 176 and 177, Amendments to the Nursing Home Act.

This afternoon we have one deputation from the Ontario Nursing Home Association, and Mr. Nightingale, and anybody else you would like to bring with you?

MR. NIGHTINGALE: Thank you, Mr. Chairman.

MR. CHAIRMAN: You were here this morning, Mr. Nightingale, so you know how we operate. You just make your presentation any way you would like, and we'll open it up for questions following that.

MR. NIGHTINGALE: Thank you very much, Mr. Chairman. I would first like to thank the Committee on Social Development for giving us the opportunity to present our views on the proposed legislation.

MR. CHAIRMAN: You have copies?

MR. NIGHTINGALE: We'll distribute them right after we give our address, if that pleases the Chairman?

MR. CHAIRMAN: Any way you like.

MR. NIGHTINGALE: Thank you very much.

He regret the fact that the Minister couldn't be here today to hear our comments, but we are pleased that the parliamentary assistant to the Minister is.

The proposed amendments to the Nursing Home Act represents for both government and the Ontario Nursing Home Association a unique opportunity to bring positive change to the system of care for the elderly in the Province of Ontario. These changes will apply to an act which was conceived in 1972 and is now badly outdated.

Fifteen years ago, nursing homes were set up to provide a minimum of one and a half hours of nursing and personal care per resident per day. The average age of a nursing home resident was seventy-five years old.

In 1987, the average nursing home resident is

eighty-six. People live longer but require much more concentrated and complex care. More and more families are unable to provide this care within their own homes. In fact, most people, including the membership of the O.N.H.A., believe it is preferable for seniors to remain at home or within the community for as long as possible.

That is, our elderly live longer. They are often critically ill and pose a real problem for families to look after. At some point, institutions become the only answer to a difficult dilemma.

The initiative to update the Nursing Home Act is a promising one. However, we are concerned that these proposed changes have not dealt with the fundamental issues that directly affect the quality of care that the elderly persons receive in nursing homes.

First, these amendments do not provide nursing homes with a clear mandate that states the exact role and function they are required to play within the continuum of care, and specifically, under the extended care program. Nursing homes were not originally set up to provide for the needs of heavy care residents. Today, because there are few alternatives, nursing homes have had to care for an increasing number of elderly persons needing a greater degree of nursing care than was required ten years ago.

While the residents and their medical conditions have altered significantly since 1972, the basic mandate under the Nursing Home Act has not. Today nursing homes and their staff are overburdened. We can assume that so too are the public homes for the aged, which are subject to the same changing resident care requirements.

I should note here that some patients currently residing in nursing homes require heavier care than some of those that are occupying hospital beds. Conversely, there are many residents in nursing homes who should be in chronic care facilities. These are all symptoms of a system badly in need of reorganization.

The second point we must stress is that once we are given a clear mandate, nursing homes need the necessary resources to carry it out. The Ministry of Health must provide the funding that will allow nursing homes to adequately satisfy each resident's assessed need. Put simply, nursing homes need more professional and nursing staff to provide the heavy care that is required for the growing number of older and more frail residents.

We think it would be worthwhile for the committee to visit one or several nursing homes to see for themselves that each resident requires a different level and type of care. The O.N.H.A. strongly believes that some type of

classification should be put into place as has been done in British Columbia, Manitoba and Nova Scotia.

The promised amendments to the Nursing Home Act and their changes indicate government's willingness to make changes to the system. However, our concern is that some of the proposed amendments might serve to exacerbate what has become a crisis situation in nursing homes rather than alleviate an already over burdened system.

In the proposed amendments, the Ministry has set out fundamental principles governing the care provided by the nursing home to the resident. Unless there is additional funding, nursing homes will have difficulty in complying with these principles. Therefore, the proposed changes will create a level of expectation among residents and their families that cannot be met because we lack the resources to do so.

In the absence of a clearly defined mandate, we don't believe that nursing homes can be effectively evaluated for meeting our goals or for being penalized for falling short of those levels of care in those goals. Instead, the proposed amendments seek to place greater accountability, greater expectations, greater control, and stronger punitive actions on nursing homes than the Ministry of Health is prepared to hold its own policies and practices accountable.

Through these proposed amendments, the Ministry is seeking to apply standards that it refuses to define or to reduce to contract, and yet the Ministry reserves the right to hold itself arbitrator and judge to determine whether or not the unwritten contract of service is being fulfilled. In all fairness, we must be told what levels of care we are expected to provide and what resources are available to do so before a performance in meeting those standards can be meaningfully evaluated.

We ask the Members of the committee to listen to our concerns. We are the people who provide care day in and day out to the 29,000 residents in the three hundred and four nursing homes in the province. We provide over fifteen million hours of resident care in a year.

Along with government, we share the public's concern for providing the best possible care for our residents. We realize the importance of working together in a cooperative manner. But as the public and political pressure mounts, we find ourselves forced into an impossible situation. We do not have the funding to increase the number of staff needed to support the heavy care residents.

When our critics in the media enter nursing homes, they witness a harried, over-worked staff looking after the

frail, elderly people. They see residents need far more than the required one-and-a-half hours of care a day and not receiving it. As a result, we find ourselves and government in a dilemma.

As the representative of both private and nonprofit members, we acknowledge that some special interest groups and some politicians have a philosophical bias against our involvement in the health care system. But we must remind the committee that our involvement was welcomed in the '60s and '70s when government and the public accepted and appreciated participation and financial support from non government sources. We didn't force our way into the system; we were asked.

MR. COOKE: Body language is not picked up by the answer.

MR. NIGHTINGALE: I also want to remind everyone that the label "private sector" is a misnomer. We are a regulated service with universal access. The amount of money government provides for each resident is set and inspections and licensing are carried out by the Ministry of Health. Everything we do is regulated. We are not the true private sector. Our role is to put the capital to pay for the bricks and mortar and to provide for good management.

In any case, studies have shown that ownership is not the issue. In 1982, the most relevant in-depth study of nursing homes undertaken by the Alberta Nursing Home Review Panel resulted in the Hyde Report. This particular study found the most significant single factor determining the quality of care provided was the quality of management. Issues of public or private ownership were largely irrelevant.

The O.N.H.A. has consistently asked the government to conduct a similar study in Ontario in order to deal with the ownership issue once and for all.

We also find it perplexing and very frustrating that in Ontario, where we are all promised universality of care, that two very different models of health care for the elderly exist under the umbrella of the extended care program; one under the Ministry of Health in a highly regulated, subject to stringent inspections; the other, public homes for the aged under the Ministry of Community and Social Services, which operates with relative freedom from regulation and is funded approximately at least thirty per cent higher than the nursing homes.

Any proposed legislative changes should recognize these basic regulatory and funding inequities that inevitably affect the quality of care given in all long

term care facilities. Universality should be the cornerstone to any new legislation. The principles set out in the proposed amendments should apply to all long term care facilities under the extended care program in Ontario, whether it be a home for the aged, a nursing home, an acute care hospital providing extended care, or chronic care facilities.

Why should we have a bill of rights only for Nursing Home residents? Shouldn't people in hospitals or homes for the aged be accorded the same legislative right?

Nursing homes should be part of the solution to the difficulties in providing long term care for Ontario seniors rather than part of the problem. Our homes are already in place in communities throughout the province and should play a role by providing day care for seniors, respite care for families, meals on wheels, all services required to help people remain in the community as long as possible.

These are the programs the O.N.H.A. has advocated for a long time. The O.N.H.A. is supportive of the many aspects of the proposed amendments, but feels that each proposed change must be carefully thought through. The O.N.H.A. has always supported a bill of rights for residents, but we believe that in order for it to be effective, such a bill should be pragmatic and in full consideration of the type of resident we care for.

The proposed amendment regarding this issue raises a number of questions. The right of the resident to accept or refuse medication is a complex one. We strongly believe that legislative protection should be built into the Act to protect the physician, staff and the nursing home who follow the resident's right to refuse medication.

Similarly, residents are bound by law to respect the rights of the staff and other residents and to treat them with dignity, courtesy and respect. Since the bill of rights is to form part of the contract, what happens if the resident fails to live by these principles? We require further clarification on this type of an issue.

Section 4 of the Nursing Home Act is amended so that the Minister shall take into account the concentration of ownership and the balance between non profit and profit oriented homes. We are concerned about how a balance can be struck while considering what is in the best public interest when extended care is provided under two separate ministries. We suggest that the total system of extended care beds be considered under this section.

Section 4 also empowers the director of the Nursing Homes Branch to refuse to issue a license to an applicant

because of past conduct or if he or she is not competent. The criteria by which these terms are evaluated must be more clearly defined.

Under the proposed Section 4a(i), the director may issue a license on the condition that the applicant agrees to satisfy specified conditions. We feel that these conditions ought to be written conditions. Without this, it is difficult to determine if the conditions have indeed been met. Also, if the director wishes to cancel the license, he or she should be required to submit in writing the conditions that have not been fulfilled. These are very basic issues with serious ramifications for any applicant entering into a venture without being fully aware of all the conditions. We have recommended amendments to clarify these points.

Section 4f(i) of the proposed legislation requires the director of the Nursing Homes Branch approve the licensee's choice of management. In effect, under this proposed amendment, the management of the nursing home is treated as the applicant or the licensee. The O.N.H.A. maintains that the licensee should be free to choose its own management, because the onus ultimately falls upon the licensee to ensure the nursing home is operated in accordance with the Act and regulations. By further involving the director in actual management of the home, the nursing home's ability to manage effectively on a daily basis may be impeded.

Section 14 of the Act is also being amended, enabling the director to permit the licensee to charge a specific amount greater than the amount prescribed by the regulations. This section opens the entire area of insured and un-insured services under the extended care program. In the past, differences have arisen in both substance and amount. We recommend that where there is an honest difference which cannot be resolved, the issue should be arbitrated by an independent third party.

The concept of expanding the function of the residents' council to a residents' council advisory committee with an advisor with broad powers raises many questions about how this mechanism will actually work. Neither the advisor's required credentials nor expertise or experience have been defined in these amendments. The mandate given to the advisor is so broad and so powerful, we seriously question the ability of the Minister to delegate such powers under these circumstances. Even our police forces cannot operate in such an unbridled fashion. This concept mixes up a form of advocacy and a complaint system and satisfies neither. We believe that the two should be separate. Both of these functions have already been shown to be beyond the capability of a body tied to the Ministry of Health.

On the other hand, we feel there is a better alternative which will accomplish the same goals with more professionalism and accountability. We'll be introducing the concept of a Citizen Complaint Review Board. This arm's length board will deal with the investigation of all complaints for all extended care facilities, and more importantly, make its findings public.

Under Section 15, the O.N.H.A. supports the concept of reporting harm perpetuated against residents. Under the proposed amendment, the director must be notified of any incidents or complaints. While we recognize the intent of this amendment to protect the resident, the right of the licensee must also be considered. We believe that the nursing home should be notified of any incident or complaint, be allowed to respond appropriately and be kept abreast of the investigation.

The proposed legislation also states that no person shall make false or malicious reports. We suggest that the legislation should state that individuals who do so contravene the Act and are punishable under the provisions of the Act. And we offer some amendments to carry out the meaning of this section.

With regard to Section 17, the O.N.H.A. has made recommendations concerning financial accountability. The association recently called for additional funding to be applied directly to resident care where it is needed with full financial reporting on a quarterly basis. This reporting would demonstrate to government and to the public that these funds were being used specifically to increase staffing. However, we believe that the public posting of financial records, as recommended in the proposed amendments, will not answer the question of true accountability in any meaningful way. Statements of profit and loss are not relevant indicators of the quality of care that the home provides. There has never been any proven relationship between quality of care and the level of profit or loss. This has already been demonstrated in the Hyde Report conducted in Alberta.

In addressing the proposed amendments, we are surely concerned with ensuring fairness and our ability to meet legal requirements and responsibilities. We have detailed our concerns in the document you are about to receive.

The fundamental issue for both the O.N.H.A. and the government, Mr. Chairman, is quality care and resident well-being. We must therefore carefully consider all aspects of the proposed legislation and their ramifications.

THE CHAIRMAN: I wonder if I could just interrupt

you for a second. It has come to my attention that at least one member of the press has what you are reading, and if that's the case, I would suggest that it would be appropriate for all members to have it as well. A member of the press has been reading it for some time.

MR. NIGHTINGALE: I apologize, Mr. Chairman.

To this end, the O.N.H.A. is anxious to share comments and views with all those concerned for the elderly. Our shared objective is to bring about positive change to the Nursing Home Act and to the entire system of care for the elderly in Ontario.

Mr. Chairman, ladies and gentlemen, we would be pleased to answer any questions you may have.

MR. CHAIRMAN: The reason I say this, this is a parliamentary procedure, and in politeness to the members they should receive the information at least at the same time as a member of the press would do so. And I would normally have it distributed to members, but as I said, I would be glad to go along with the way you wanted because it's helpful to the members to be able to ask questions following the presentation.

MR. NIGHTINGALE: I apologize for any indiscretion, Mr. Chairman.

MR. JACKSON: Anybody who watches Question Period, Mr. Chairman, would understand that, possibly with the new accepted procedure under the new government, whereas you know it arose several times during Question Period in the House.

MR. CHAIRMAN: It was never left unsaid from the opposition when it occurred. I noticed.

MR. JACKSON: That's correct.

MR. CHAIRMAN: Mr. Cooke.

MR. COOKE: Thank you, Mr. Chairman.

Just how many of the Nursing homes in Ontario belong to the Ontario Nursing Home Association?

MR. NIGHTINGALE: I believe three hundred and five, Mr. Chairman, out of about three hundred and fifteen or ---

MR. COOKE: Are there any of the non profits in the Ontario Nursing Home Association?

MR. NIGHTINGALE: We have seventeen non profits of those.

MR. COOKE: Under the Nursing Home Act?

MR. NIGHTINGALE: No. There are seventeen non profit nursing homes that are members of our association. I don't know the total number.

MR. COOKE: Can you give me any idea at all of what the level of profits are in the nursing homes who are members of your association?

MR. NIGHTINGALE: We have been in the process of collecting that data, and an answer is no, I don't have the totality of all the results that we are collecting to share with the Ministry for other purposes.

MR. COOKE: You, or your association, at a press conference that was held in Toronto, I guess it was last year when you announced your proposal for an extra...I forget the amount of money, a hundred and something ---

MR. NIGHTINGALE: A hundred and seventy-three million.

MR. COOKE: A hundred and seventy-three million, a very, very modest amount of money. But in any case, you indicated that up until 1979, financial data had been filed with the Ministry of Health?

MR. NIGHTINGALE: Correct.

MR. COOKE: Can you indicate to me what exactly that financial data was?

MR. STEVENS: Yes, sir, I can.

The financial data was an income and expense statement that was done on a form devised by the Ministry of Health, and it included dollars and it included hours of care provided in each wage group. There were two forms that we sent in quarterly to the Ministry of Health.

MR. COOKE: So that would give an indication of what the profit levels were as well?

MR. STEVENS: In some ballpark, yes. The forms really weren't complete in that they didn't ask for all the information with regards to depreciation or some various capital costs. So not all profit was shown. But it came down as far as the Ministry wanted at that time. This was their form, sir.

MR. COOKE: That was stopped in 1979?

MR. STEVENS: I believe so.

MR. COOKE: Do you know the reason why the Ministry of Health stopped collection of that?

MR. STEVENS: No, sir. One day we got an amendment to the Nursing Home Act and it was removed.

MR. COOKE: And I guess it would be an amendment to the Regulations ---

MR. STEVENS: The Regulations had been amended.

MR. COOKE: -- rather than an amendment to the Act.

I would appreciate at some point before we, perhaps whenever you can get it for us, tomorrow or whenever, an explanation as to why that was ceased, and any information that might be available, up until that date, that would be helpful to the committee in determining what profit levels were up to that point, since certainly one of the items being discussed is profit versus nonprofit homes under the amendments.

THE CHAIRMAN: And one would be some notion up to that point, from the data which was collected, as to what the financial situation was....

MR. COOKE: Right.

THE CHAIRMAN: ...and the other would be why the regulations were adjusted so that was no longer required.

MR. COOKE: Right.

THE CHAIRMAN: Okay. Thank you.

MR. COOKE: You indicate that the Act doesn't clearly set out your mandate. What do you think the mandate of the nursing homes in this province should be?

MR. NIGHTINGALE: It may sound capricious, Mr. Chairman. It's really what government wants to define it to be, relative to its concept of continuum of care.

The Act, as you know, currently maintains we have to provide a minimum of one and a half hours of care. Chronic care starts at four hours of care. There is a gap in this system between one-and-a-half to two hours of care up to four hours. If government wants us to provide between one-and-a-half and two, let it define it so and let the residents who require more care be appropriately placed.

It's not a chicken and egg, but it's a reality of an open debate by the community at large and the Ministry of who should be doing what for whom.

MR. COOKE: So basically some kind of an explanation of how heavy the care can be in a nursing home so that there isn't the broad mix of residents that currently exists?

MR. NIGHTINGALE: Very simply, that we have over three hundred homes throughout the province, and you recognize that in certain small communities, there may not be a chronic care hospital close by, and that nursing home therefore becomes, over time, the health care provider for the total care that that person requires, even though they may require something beyond that.

MR. STEVENS: The extended care form, as it was laid out in 1972, and mostly the same right now, has no upper limit. I have not been part of the process in approving extended care, of course, but you begin to realize that they get approved when they get over so many points on the form, and over those number of points, you are approved for extended care.

Well, you could be acutely ill with cancer and get yourself approved for extended care because you need more care than what's shown on that form. It doesn't relate to longterm care. It doesn't relate to our role.

MR. COOKE: But it's also true though that, take for example an Alzheimer patient, or somebody that has Lou Gehrig's disease -- and both of those I have had in my community -- it's fair to say that if they have that diagnosis at the nursing home, that they may in fact have an extended care certificate, but they may in fact have no nursing home that's willing to take them because of their heavy care.

So I don't think you are saying, and I hope you are not saying, that just because somebody has an extended care certificate, the nursing home is obliged to take the resident?

MR. STEVENS: No, sir.

MR. COOKE: In fact, in many cases he can't find a nursing home to take them.

MR. STEVENS: That's not what I am saying at all. I am saying that before you have an open ended system where anybody can get an extended care certificate, you need to tell us how much care we should be providing. You need to say to us, not over four hours, not over three hours. You need to say on that form: This is not an extended care person; this is a chronic hospital person; this is an acute hospital person.

We are not licensed to perform operations.

MR. COOKE: -- because certainly my experience with a few of the placement officers is that -- and I've been told on many occasions that, "I'm sorry. That person is not an extended care resident but is a chronic care patient, and therefore we are not putting the person on a waiting list for a nursing home."

MR. STEVENS: I think the placement service has been most cooperative and most helpful with all our goals, trying to look after the people in our community. That doesn't necessarily help solve the global picture, though, of what our role is and what the role of a chronic hospital is and what is the difference.

MR. COOKE: I'm just saying it should be helpful in screening out ---

MR. STEVENS: That's right.

MR. COOKE: -- chronic care patients.

MR. STEVENS: Yes. But then the second problem is that patients who are in our home who regress, and they need more care, and if they regress, do we have the right to ask for placement coordinating services assistance in moving to a chronic hospital? And under these proposed amendments, how do we cope with that if the resident doesn't want to move, and may that be in the best rights of the resident? And I have deep concerns about that.

MR. COOKE: All right.

I would like to just ask your opinion on the statement of fundamental principles in the proposed legislation which you refer to as a bill of rights. But I don't see them, as it's outlined in the proposed legislation, as a bill of rights.

From you looking at it, your association looking at it, how do you foresee that section of the legislation being implemented, or being enforced?

MR. NIGHTINGALE: That's an excellent question, and we don't have a pat answer. It's very simply one of, we understand and we are supportive of a concept, but we have difficulties when the proposed amendment says it shall form part of the contract.

I mean, we can understand that people ought to be treated in a certain way. Nobody objects to that type of thing. But when you put it in as part of a contract, you are changing the relationship between the care provider and the person receiving the care. It's now a contract of law. And in so doing -- I am not a lawyer -- but it does

establish a different type of relationship.

MR. COOKE: Whose responsibility at that point then is it to enforce? Is it not the resident's, as you would see it?

MR. NIGHTINGALE: It could be the resident's, and alternatively, it could be in a situation where the resident violates that contract, if you like. What are we supposed to do; throw him out, if they keep not respecting other people's rights, not being appropriate, supposed good citizens? I mean, it's perplexing for us.

On the other hand, we are supportive of what it's trying to achieve. But there are certain aspects of it, such as the right to refuse medication or give consent to medication -- which, very frankly, I will leave it to the medical profession to speak to -- but because of the type of people we look after, many have many forms of dementia, of Alzheimer's.

You are going to need everyone to have a psychiatric examination to determine whether or not they are competent to give consent, and then if they are not competent to give consent, define either the legal guardian or someone from government to then make the decision whether or not they are to receive medication or refuse medication. Those are problems. We understand the problem, but we don't have the standard solution for you, with all due respect, Mr. Chairman.

MR. COOKE: Obviously, one of the difficulties with medication, of course, is that there is great concern. People who have looked at the nursing home system looked at the care of the elderly in general -- not just at the nursing home system -- that medication is all too often used, and that medication...residents don't always know what kind of medication they're getting.

I mean, even in a document that was released last year by the Conservative Party, it indicated their great concern as well about residents being massively controlled by drugs. And you remember that document received a considerable amount of publicity in the press.

MR. NIGHTINGALE: Well, Mr. Chairman, the only way I can respond to that is that nursing homes don't medicate people. We can't give medications, as some of you may know. It's done by the advisory physician or their own attending physician who prescribes medication. And if he prescribes notice of medication be given, that the nursing staff must so do, because if they don't, they are liable the other way.

Secondly, the whole area of medications, and I hear

a lot about it. I have yet to see documented evidence to say that anybody was being over medicated. I know we hear it. I'm not being defensive about it. But the reality is that if the nursing home people don't do it, there are certain procedures that are followed, and it's namely the advisory physician.

MR. COOKE: With your stated lack of funding, your stated lack of funding -- I am not necessarily agreeing with you -- but with your stated lack of funding, do you believe generally that the nursing homes of this province are meeting the terms of the current legislation?

MR. NIGHTINGALE: No.

MR. COOKE: I think at your press conference you indicated no.

MR. NIGHTINGALE: The answer we have, Mr. Chairman, we have reviewed a number, over the years, a number of requests that have been held, and what they said. We reviewed the London Jury Recommendations Report. We reviewed the Leisure World Inquest. We reviewed the Crittendon Report. We reviewed the various submissions made to all the parties to the various specialist interest groups. And they all said one same thing: there needs to be more staffing.

We have presented to the government, based upon those reports, an analysis, a call for increasing the basic levels of care, or at least the number of minutes of care per resident per day by forty. We have called for adding one additional Registered Nurse to better assist in the in-service program education and infection control on the basis of one for every sixty residents.

We have called for an increase in the facilities, the people in the kitchen facilities to carry out good infection control programs. We have called for social workers.

All the things all these reports have said; that's what we did. We costed it out at \$173 million. So that we think there is a lot more that has to be done, not because we say so, but because there is a lot of people that agree with us.

MR. COOKE: In your press conference that you held, and I think you reiterated it here today, your support for financial accountability is financial accountability on that \$173 million only?

MR. NIGHTINGALE: No. We have always maintained -- let's talk about a financial model, if you like, or some type of accountability system. But the real thrust of all the positions has been the public posting, if you really

want to get down to it, public posting in someone's place of business.

We have no qualms about submitting it to government. And the reason, among many of our members, is that the rule of thumb should be that anybody that receives public money or money from government ought to be accountable and post their financial statements. We don't have a problem with that, if that's the principle, to apply to the people who build hospitals and make money, or any type of way government gives grants. Whatever way government gives people money, let them post it in their place of business, if that's the principle.

On the other hand, if that principle is to be avoided and only picked to one certain group, to do so, we have a problem.

MR. COOKE: I don't think anyone is picking one particular group, the private ambulance services, hospitals, homes for the aged. Virtually anything else, where there is direct delivery of service in the Minister of Health, there is budget approval by the Ministry of Health.

MR. NIGHTINGALE: Mr. Chairman, I don't want to get argumentative, because even though they post their financials doesn't really tell you what they spent the money on or how it went or the level of service being provided for those dollars.

MR. COOKE: Do you not think that it's appropriate, though, since there is a co-payment involved and the residents are paying that co-payment, that they should have access to financial statements so that they know how their money is being spent?

MR. NIGHTINGALE: Mr. Chairman, there were different philosophical views. People go to dentists and you pay them out of your pocket; are you entitled to know what he makes?

MR. COOKE: You know exactly what service you are getting; you can usually feel it.

MR. NIGHTINGALE: Well, the difference is, Mr. Chairman, we don't make the rules. The whole Nursing Home Act are rules that have been established by government. It's been government's little game, if you like. They have set the rules forward by which we shall play.

Unfortunately, over a period of time, the rules have shifted as a result of the type of people we are caring for. If we were still back in 1972 looking after the rest of the profile of 1972, I think you may have a good

argument. I think it changes pretty dramatically for the type of people we are looking after now.

And still, to get back to your point, we haven't seen anybody to show the relationship between posting ones' financial statements and the quality of care being delivered.

MR. COOKE: Well, we haven't tried it. We will.

MR. STEVENS: I would like to add, if I may, if the government was prepared to talk about a budget based process where they met the needs so that each home could have staffing to meet the individual need of each resident and be funded accordingly, we all would probably be only too glad to post our financial statements. But the situation, as it now is, is that the deficit that has to go on to provide the needs of the residents is solely at the cost of the owners of the nursing home and not of this government in their caring for the elderly.

MR. COOKE: That's assuming there is a loss.

MR. STEVENS: Well, sir, you can assume; I know.

MR. COOKE: Well, your nursing home might -- I don't know -- your nursing home might be losing money, but Extended Care seems to be doing quite well. I mean, there are a number of them. There is a local nursing home operator in my community that owned three, offered to show me his financial records for Essex Nursing Home but not for Tecumseh and Riverside, because that's where they were making a profit. I mean, you are not going to tell me that out of the three hundred and something nursing homes in this province that they are all losing money.

MR. STEVENS: No, sir, we won't. And I tell you that they should make a profit, because that's what you are paying us to do.

MR. COOKE: No, I am not paying you to make a profit. I am paying you to provide quality of care.

MR. STEVENS: But you use our services in three ways: You use our services to provide capital; you use our services on management expertise; and you use our service to provide efficiency and effective service. And you put us at risk in that process.

When you ask for efficiency and effective management and you put us at risk, we have a right to make a profit if we are smart enough to do that. If that means poor quality care, then we are not giving the service that you are buying and we should be in jeopardy. But if we are providing good quality care and making a profit, then that

should please you also.

MR. COOKE: You see, the thing that I can't understand is that if the system is so under-funded, how is it that Extended Care is still making money?

MR. NIGHTINGALE: Well, Mr. Chairman, in all fairness, Extended Care is not the group -- I mean, there are many -- one of the things we export in terms of Canadian expertise to the United States is our expertise in health care, longterm care. And unless you want to speak to Extended Care, or any other company that's operating in the United States or other jurisdictions, I think that's the appropriate place to ask that type of question.

MR. COOKE: Well, one could say that Extended Care in their operations in Ontario are simply operating under the terms and principles of American health care in Ontario. However....

One other question, and that is: What would your, if you believe in this process of a public complaints committee, how about looking at the approach, or what would your reaction be to a public hearing upon annual renewal of licenses, issuing of new licenses, transfer of ownership, in which residents, relatives of residents, members of the community and staff would have the opportunity to publicly testify and review all inspections in the last year and complaints and concerns in front of the licensing people before the decisions to re-issue a license is made?

MR. NIGHTINGALE: Mr. Chairman, I can't answer yes or no, so I am not for it or against it. I would have to look at it in light of the other programs and other mechanisms, how this thing, how the proposed amendments finally end up with, before I could really answer that type of question. Because there may be better ways of doing it, more immediate than at the end of the year, to deal with certain problems, as opposed to waiting for an annual licensing. Perhaps deal with them throughout the course of the year, or monthly, or some other mechanisms.

So in all fairness, I think I reserve answering that question until I saw how the rest of the pieces came together.

MR. CHAIRMAN: Mr. Andrewes is next.

I also presume, because of going over your document now, I see that you have tried to lay out as clearly as you can the amendments that you think at the moment would apply, that you didn't have time to go into in your actual oral presentation except to allude to some of the major areas you have been going to, that members may have had some difficulty assimilating this at the moment.

But if as we go on, and perhaps at the stage where we have some idea of where the amendments may be going, I presume you will be auditing us, and would you be available to come back, if necessary?

MR. NIGHTINGALE: Mr. Chairman, I appreciate the Chairman's consideration very much. I will be auditing throughout, and I was going to ask the committee at the end if I may return to make some closing remarks, at the end of the entire process?

MR. CHAIRMAN: I think that I leave that up to the committee to decide as we go along. If you are around, then we can definitely chat about that with you.

But it seems to me that there are a lot of people who obviously haven't had a chance to digest this a little better and would probably like a chance to ask you questions again later on.

Mr. Andrews, sorry.

MR. ANDREWES: Thanks, Mr. Chairman. I wanted to come back to the point of the mandate, I think in response to Mr. Cooke's suggestion, that the government needs to tell you what they expect of you, what services they expect you to provide. Is that your preference?

MR. NIGHTINGALE: I think government, or the Ministry should define whatever our role is, relative to the type of resident they define that we should be looking after. It's both. And do that in open discussion with us.

Many of our nursing homes, for example, are prepared to undertake chronic care if that's -- if they are prepared and the Ministry is prepared, you have got a process. We are very flexible, is our answer, Mr. Chairman, to deal with government and to address this issue.

MR. ANDREWES: I guess what I am concerned about is how narrow or how broad that mandate is. And in consideration of residents and their desire at one stage to establish themselves in an institution, how narrow or how broad the mandate should be. Because it's certainly not appropriate in many cases to move people out.

If the mandate were clearly defined and that an hour and a half a day was the extent to which a nursing home was to provide care, what do you do when the resident needs more than that hour and a half? Do you move them out? Is that your choice?

MR. STEVENS: Sir, thank you very much. But I think the concept in the '70s of one building providing all

levels of care may have become passe. It's not passe in the fact that residents live in our homes; residents find their friends around them and they like the staff around them. But as their health diminishes, they may require more care to be provided, not just in numbers, not in numbers of nurse aides or R.N.'s or R.N.A.'s or social workers, but in other specialties.

They may have to have constant medical attention, which automatically kicks you into the next level of care of chronic hospital. They may require physiotherapists, and today you realize that we are not allowed to have physiotherapists work in nursing homes. They won't license any physiotherapists in nursing homes. And I think our residents or patients require some of that at times.

And so there becomes a need. Either you bring the people to the nursing home or you take that resident to where it's more appropriately given. So when we were saying that you should give us some direction as government on what you expect from us, I'd like to relate that back to the statement of the Minister a few months ago that he wants nursing homes to become accountable.

Well, my staff asks -- I ask my staff to be accountable the very same way the Minister asks us to be accountable. But for me to do that, I owe them a couple of things. I need to set out in front of them a clear set of guidelines and goals we agreed upon mutually that they should achieve. And then I should measure them against those guidelines and goals as if whether they achieved or did not achieve or became accountable.

I believe in our current situation, what we have now is to have no goals or guidelines set out for us so that we know what the Minister wants. But we are always -- quote -- unaccountable on achieving what he wants.

So I think that grey area out there that we're not sure what we should be doing is perhaps the problem of some of the mis-communications. And I think I should, you know, that if we cleared the air and he outlined more precisely what the program was about, made it more contemporary to 1987....

The one issue too about moving patients between facilities: It's been my experience over fifteen years that the residents that I deal with are winners in our society. These people have coped with more change than you and I have seen in our lifetime, and more difficult. And their ability to cope with change is tremendous.

Moving a resident, moving a patient is not critical if it's done correctly. So the real question should not be, should we move the patient, but how do we move the

patient, how do we re-orient them to the new place. It is not, sir, by ambulance on a cart and dumped in a hallway in a hospital. There's a lot better ways of doing it. But they can be successfully moved without complete disorientation of their life or their lifestyle.

MR. ANDREWES: If in fact the mandate were broadened and you could provide that continuum of care that we've talked about, within sort of the limits I would assume that you would want placed on you, can you give me some idea as to the ability of the nursing home sector to provide that broad-based care?

MR. STEVENS: Yes, sir. We certainly can do the job that was laid out for us in 1972. That's about the one-and-a-half to two hours of care and that concept of a resident. We have accepted new challenges in that last four or five years. We have looked after heavier residents, residents who are totally incontinent, who in 1972 were not part of the nursing home system, residents who are confused through dementia or Alzheimer's -- and in my nursing home we have a thirty-bed Alzheimer's wing specializing in care for the Alzheimer. The staff -- it is heavier than normal staffing levels, but still under-staffed. It could use four hours of care a day and maybe not meet their needs.

We can certainly look after various groups of people who are basically needing a place to live, constant medical attention, and with supervisory physician coming in when needed.

I don't think we can go as far with constant medical attention, and I think the only other program that may look after the late '80s would be physiotherapy that we could add into our facilities.

MR. ANDREWES: The entry point now for a resident is this one-and-a-half to two hours per day. Is that a reasonable entry point? Is there an opportunity for people under that kind of guideline to remain outside of an institution, or should that entry point be moved back or forward?

MR. STEVENS: First of all, it's my other observation that the home care program is working. I come from London, and we have very good home care in our area. So the type of resident that comes to the front door of my nursing home doesn't require an hour-and-a-half of care. They require an awful lot more care before they are admitted. That's why you see the things like the average age go from seventy-five to eighty-five.

They have really stayed in the community as long as possible. So that perhaps the committee may want to

consider changing the rules so that the OHIP Extended Care Act doesn't kick in until they require, say, two hours of care a day. Perhaps you would want to make sure that the people already in the homes were sort of green-circled or red-circled so they wouldn't lose their rights. But there is no reason why you can't.

And I guess if the government truly believes in home care and supporting people in their community, they may want to consider the concept of changing the Extended Care Agreement so that they are admitted at a heavier level. I don't think our industry would object to that at all. We have been a strong proponent of home care for a long time.

Part of the problem that we face and our administrators face is that we get the phone calls every day from families desperately needing nursing homes. We have lobbies of friends phoning us up doing in-runs trying to find nursing home beds. That happens continuously, I'm sure as you know, sir.

MR. ANDREWES: And politicians too, I am sure.

MR. STEVENS: Yes, I know. We get phone calls from politicians who phone us, "get the beds".

MR. ANDREWES: In Alberta, the Hyde Report; could you tell me a little more about that?

MR. NIGHTINGALE: Mr. Chairman, in Alberta, Alberta was going through the same type of discussion we are going through somewhat. And in order to deal with it on a more empirical basis, the panel was formed under Dr. Hyde, and they went under a set of criteria looking at primarily programs, levels care and funding, and visited for-profit homes, the charitable homes, and municipal run homes. And they compared their findings by actually visiting them to see the types of programs that were provided, the care being provided and the level of funding.

As a result of that, the major observation that came out of that report was that there were good and poor homes in all levels: in private homes, charitable homes and municipal homes. And they found the interesting variable in the quality aspect was the management.

As a result of going through that experience on an empirical basis, Alberta has begun the process of modifying the Nursing Home Act to increase substantially the funding to the private sector to parallel that of, or very close to, the homes for the aged sector, and are applying the same set of principles to both sectors to make sure there is a check and balance on the system, the homes for the aged, the charitables and the nursing homes ought to, because they are looking after the same type of people,

ought to be providing the same level of care based upon the equal dollars available. And it's a good process.

They've undertaken a number of steps. They were a little bit further behind than us at one point, but now the Government of Alberta, through their Ministry of Health having done the empirical work, are now taking the programs and putting them in place to rectify the past situation.

MR. ANDREWES: You talked about universality. I know there is a fairly extensive review of services for elderly people going on now by Mr. Van Horn, which may in fact lead what's, I guess, loosely described as the new Extended Care Act. I assume that that's really what you are saying: that if one is to deal with elderly people and with the difference in institutions, that it has to be done fairly equally, and the only way it can be done is to apply the Act, one Act to all the institutions that are involved in providing the care?

MR. NIGHTINGALE: Mr. Chairman, the one thesis, the major thesis we want to leave the committee with is that we are looking at a system where it would have been preferable, if you may, with all due respect, to have this type of discussion after Mr. Van Horn would have completed his enunciation of the Extended Care Program and the changes he would introduce. Thereby we would have a better understanding of who it is we are to provide care for, and then have in place how we are to be evaluated and the criteria of evaluation and the licensing renewal or the licensing revocation based upon criteria of performance.

Here we are perhaps a year, two years, before Mr. Van Horn will bring out his report, only dealing with one side of the coin, and that is from our point of view perhaps the more controlled or punitive side, and not the major or substantive issue, the quality of residents and the care we provide them.

We are suggesting, as Mr. Andrewes has said, it is exactly that. There should not be any difference over the types of rules or inspections or regulations or funding model between a home for the aged and a nursing home providing the care to the same person under the Extended Care Program.

I listened with interest this morning to Mr. Cooke's observation and the pre meeting aspect of it, and in certain ways I agreed and concur very much with Mr. Cooke in some of his observations about nursing home revocation or certain actions. On the other hand, I would like to see those same rules applied immediately to any other government agency or group, whoever, who operate a nursing home or home for the aged who also don't perform.

Because we operate under the principle that if you are a citizen of Ontario, you are entitled to the same service under the Extended Care Program, not first class or second class service. And that's the fundamental principle we want to achieve: universality for all, one system, one funding model, and one inspection system for everybody.

MR. ANDREWES: I am not sure, Mr. Chairman, if our efforts on the Select Committee for Health and Social Services will result in the Hyde Report, but I think directionally it hopefully will deal with the issue that you raised, and it relates somewhat to your statement that issues of public and private ownership were largely irrelevant. I don't know whether that will be the outcome of that committee's work, but if we get to the nursing home sector, we hopefully can resolve that issue.

THE CHAIRMAN: Would it be of interest to the members for me to get copies of the Hyde Report and forward it to you and have a look at it?

MR. ANDREWES: Yes.

You heard the Ontario Nurses Association this morning; I believe you were here for their presentation....

MR. NIGHTINGALE: Yes.

MR. ANDREWES: ...where they talked about under funding in the system. They talked about funding a system based on the patient's needs. Is that a desirable direction, and how would you make that assessment, of the patient's needs?

MR. NIGHTINGALE: Mr. Chairman, there are a number of assessment tools. Some members of this committee have a significant health degree backgrounds and who understand that there are a number of assessment tools out there by which residents' assessed needs can be measured using various instruments, and then you break it down by applying the various resources or professional aspects to meeting those needs. It's not theoretical; it's very pragmatic. It's there and it can be used. Unfortunately, we haven't been able to move this government to the point of implementing such a thing. But it is, to be fair, under study right now of looking at various assessment tools.

So to a certain degree we are moving in that direction of looking at the tools that could be applied. And there may not be anything wrong with funding to the specific need, or to fund for levels of need, like in British Columbia, Manitoba and Nova Scotia.

MR. ANDREWES: The point of the bill of rights; you talked about it needing to be pragmatic. Tell me what that means.

MR. NIGHTINGALE: "Pragmatic" means in a sense that you and I, we are not going to be in the nursing home day in and day out. There has to be some type of ongoing encouragement for the staff, families and the residents to exist in a harmonious environment; "pragmatic" in the sense that you are outlining certain expectations. And there is nothing wrong with creating and putting into some statute, government regulation, white paper -- I don't know -- natural expectations, and no differently than schools have expectations of students in the way we are going to conduct ourselves. That to me is pragmatic.

When you change it and put it as part of a contract, as part of a contract, you are changing the type of working environment and relationship you want to have to a contractual one, where one party may have to keep looking at, "Am I doing this or am I going to be sued if I don't?" And the other one is worried about if grandfather over-reacts and does certain things and hits other residents, what can happen? Do they throw him out? That's what we're after. That's what we're after achieving.

But having the experience I've had and looking at the different legislation, whatever was decided here, people may forget five or ten years from now and we may be into a different ballgame. And that's what I mean by pragmatic: looking at the ideal and looking at the type of environment you may want to have, but not changing the implementation by changing the relationship through law.

That is in fact what the legislation purports to do.

MR. ANDREWES: But surely the contract or the -- I think the amendment describes it as a statement of principle, and you call it a contract. Surely that wouldn't require punitive action against the demented patient that physically hits someone else. Is that what you are saying?

MR. NIGHTINGALE: From a pragmatic point of view, Mr. Chairman, the answer is no. But what do you do with a family reading the proposed major principles of providing psychological, social, cultural, spiritual -- I think there is one more -- who say, "my family is entitled to all of that. You are not providing that." And even though those are principles in the Act, that Act has now been tied to a contract.

You are not providing enough. It may be quantitative; it may be totally absent. And then we are going to go into lawsuits. That is a little concern of ours, that we don't start spending health dollars in lawsuits. Because there is a natural expectation of families that the nursing homes shall meet these expectations for major principles. And

has already been mentioned, physiotherapy, there may not be certain services available in the community to do that. Yet, it's their law.

MR. ANDREWES: Could you expand, Mr. Nightingale, a little bit on the concept of a citizen complaint review board?

MR. NIGHTINGALE: Mr. Chairman, I refer the members to page thirty-two, if my memory is right. Yes. Page thirty-two. We have been looking at a number of issues, and I may start first, Mr. Chairman, that we did not deal with the issue of advocacy because the Minister had proposed to leave it to another independent committee. We have remained seized on that one and just deal with this.

We feel that there is room in the process, and we suggest, but one of the disadvantages that we have has always been to react to accusations, innuendo, or people not feeling they have a place to make a complaint. I mean, we'd be frustrated with the Ministry process of making the complaint with the Ministry.

We want everything out in the open just as much as anybody else, or else, how else can you deal with it effectively? And we have advocated an independent citizens' complaint board. You may look at it much in terms of the Humans Rights Commission concept, where you have trained people in a certain area where a complaint is lodged, written or otherwise, to go into a longterm care facility, investigate it, try to resolve it, but in any case, make it public and report the findings both in the home and to the Ministry.

And we outline on page thirty-two some of -- the basic intent is really to resolve some of the disputes, or if they can't, to make them public and refer it to the Ministry, and even more important, if through that investigatin they feel that the safety and welfare of the residents are in jeopardy, to immediately bring in the Ministry who then now, under the other proposed amendments -- both under the Special Health Facilities Act and other proposed amendments here -- can act immediately.

And we think it's a good way of getting a lot of this stuff out in the air to deal with it in a way that it can be dealt with, lead the Ministry inspection process to inspection, leave an independent body to deal with complaints and open up the system.

And we feel that this is again, Mr. Chairman -- and it's subject to further development, if you like -- but it at least opens up the issue to proper investigation by people who are accountable, and public posting of the results of their investigation. That's public

accountability.

MR. ANDREWES: Finally, Mr. Chairman, you made a statement, Mr. Nightingale, on page 12:

There has never being any proven relationship between quality of care and level of profit or loss.

I guess that really summarizes the ideological arguments that we have in this committee and others from time to time. Can you make that statement honestly? Can you tell us that there has never been any proven relationship?

MR. NIGHTINGALE: I have never seen any. As a matter of fact, Mr. Chairman, there is curving, which we will be submitting under the Health Select Committee on Human Resources....

MR. ANDREWES: Health and Social Services?

MR. NIGHTINGALE: ...and there is a recent study of a Harvard University Professor who looked at both private hospitals, private sector hospitals in the United States, and public ones, a very detailed empirical study, which proves exactly that. There is the Jake Epp study out of Ottawa -- I am talking off the top of my head; I kind of recall them -- the Hyde Report in Alberta, who have all showed that there is not that type of relationship between profit or non profit and quality of care.

I don't know if there are. I'm not aware of any that show definitely, without question, there is a relationship between profit and poor care, or if you like, no profit and better care. As a matter of fact, there is poor and good in all categories, without doubt. So to the best of my knowledge, the answer is I don't know of any of those studies.

MR. ANDREWES: Thank you, Mr. Chairman.

MR. CHAIRMAN: Mr. Baetz.

MR. BAETZ: Just to continue on for a moment on the subject of profit, we have heard of levels of profit here, and so forth. And I was just wondering, has the Ministry or have you, or has anybody, ever indicated what might be, let's call it, an ethical level of profit? I know that some people around this table, of course, would say "profit" is a dirty word in the nursing home field and it should be out of it entirely. But does either the Ministry or do you, have you ever tried to think in terms of what would be a fair ethical level of profit?

MR. NIGHTINGALE: Mr. Chairman, it's a complex issue, depending on how much equity one has in the facility, and everything else.

The one idea -- and it's only an idea -- that we were toying with is the question of that whole issue of profits being turned over to a utility, a group almost like a utility board that determines their level of what they can charge and what level of profit they can make.

Because everybody's situation is different, depending on when they started the nursing home, when they became involved in this, how much equity, how much money they put up front, how much equity they are providing, the age of the capital site. There are a number, so many variables, to say this is the acceptable level. It will hurt some and benefit others. So it's not that simple.

But we are looking at the issue, trying to deal with the issue of profit, because it may offend some people -- it doesn't offend us -- to deal with it in a more pragmatic and rational fashion and get it out of the area of rhetoric and accusation. And one way of doing it may be through some type of independent utility body which will set that type of rate or level, like they do in the telephone system or Hydro, or whatever. It's just a concept that we are looking at.

MR. BAETZ: I am pleased you have made that suggestion, because really, simply because we have no idea of what a proper level or a decent level of profit is, we tend to get engaged in rhetoric. And some people think there are enormous profits being made, and others, of course, would say that that's not the case.

MR. NIGHTINGALE: Mr. Chairman, if I could just add, we have a number of nonprofit nursing homes who don't operate for a profit and are still struggling under this legislation, like everybody else, to make ends meet to provide the care that people accept. Even our nonprofits still can not deliver the care required or expected by the Ministry and the public.

MR. BAETZ: Because quite frankly, Mr. Chairman, you know, without a total financial statement, including the profit, I don't see much merit or even any way of providing some clarification to the residents, or anybody else that is interested, when you post a financial statement that simply says what did you pay for services and what did you pay for food. I mean, that in isolation, that by itself doesn't tell you a heck of a lot. It doesn't tell you anything. It doesn't tell government anything. It doesn't tell anybody anything.

Now, the other point that you were making which I

found rather interesting, and perhaps other members around the committee have heard of it before, but the concept of a bill of rights, if you want to use that word, for the operators, if you are going to talk about a bill of rights for the residents.

And I must say, Mr. Chairman, I rather like that idea, and I'll tell you why. Because we talk about this as being the home of these people. Well, in the residential world, we talk about a bill of rights for tenants, but we also take about a bill of rights for landlords. And so maybe as we move into this and begin to specify and articulate a proper bill of right for tenants, for residents, we ought to be spending sometime on a bill of rights for the operators.

Have you people taken any steps in that direction? Has your association or your independent operators, or anybody, have you said, "Here is what we see would be a workable bill of rights for us"?

MR. NIGHTINGALE: We have talked about it, Mr. Chairman, but both concepts are wrong because of the type of area we work in. It may be good for tenants; people that are healthy can make those types of decisions and look for alternatives. It may be good under those types of conditions.

But when we really look -- again, we really haven't dealt with it -- but when we really look at the type of people we are looking after and the type of environment we are looking after, it may or may not work, is what I am getting at, but rather, what we have to do....

If you provide the care, the real answer to the question, if you meet families' expectations and residents' expectations; if you provide the staffing and professional development to assist the staff to give the care you want, you've solved ninety per cent of the problems. That's the guts of the issue.

MR. BAETZ: That's always a very relative; that's always an open ended; what is "adequate"?

MR. NIGHTINGALE: That's right.

MR. BAETZ: You know, it's a constantly changing measurement as well, I might say.

MR. NIGHTINGALE: Yes.

MR. CHAIRMAN: Miss Hart.

MS HART: Just on that point, I am running that concept through my mind, a bill of rights for the

operators.

Would you see that encompassing prosecuting of residents? Doesn't that get you into a whole can of worms?

MR. NIGHTINGALE: I would never want to be in a position of having to prosecute a resident. I can't answer for everybody. Don't

MR. STEVENS: Just a question I have to raise, though, is that under the area of reporting abuse, I am uncertain as to whether you want us to report abuse of one resident on another resident, and I'm uncertain if you want us to report abuses of family on a resident. So when you are doing your considerations, think about that.

The one abuse that I have dealt with extensively in our homes is families who take pension cheques and do not look after their families with them. They are processed in the way of going through the Canadian Pension people and they go in and they investigate and they get up the money and give it to us to handle through trust accounts. But that's an area of abuse that we deal with all the time. So as the legislation now stands, we would feel obligated to send all of those in, of course, for investigation.

MS HART: Mr. Stevens, perhaps I could pursue with you: You mentioned that you had an Alzheimer's unit in your residence?

MR. STEVENS: Yes.

MS HART: In the amendments as they currently stand, there is a provision in Section 13 for contracts for funding for specific services, and what is contemplated is just such extra staffing required for residents that need extra care.

MR. STEVENS: Right.

MS HART: Would you have a comment on the delivery of funding? Is that something you can live with by contract?

MR. STEVENS: Yes, and I look forward to that going as part of the legislation, and I've already promised the ministry I will be the first in line to be asking for this process. We built this unit as an experiment. It is a year old now. We have some apprehensions to the process. The apprehensions are that a year later our residents need much more care than when we admitted them.

The Alzheimer's people last a long time. It's a devastating process. They certainly step down in their ability to cope with the world and step up in their

requirement for care. But there is no downstream place to send them. If they are violent, you might get psychiatric help at a psychiatric hospital, but there is no other place to go. And so when you admit them to the home, you take on an unlimited liability as they get heavier and heavier and heavier.

The second liability, of course, is in the families who are going through devastating times at the very same time, seeing their loved ones just being crushed by something they can't explain. It's probably worse than death by cancer because they see this person change in front of their eyes. And their frustration and their needs have to be dealt with too. And frankly, in nursing homes, we are not equipped for that. We don't have psychiatrists. We don't have social workers. We don't have that type of professional staff to cope with families of Alzheimer's residents.

But I think we could if we had enough staff, enough funding to provide that staff. Like, it's a process way beyond anything we've touched so far. Psychically, the building that we've designed can handle them. Physically, the space is more than adequate. We can't overcome them going through people's and other people's drawers. We can't handle family expecting them all dressed up nice and cute every night if our program is intended to have them dressing themselves appropriately for themselves. But I think nursing homes can handle Alzheimer's patients, but it takes an awful lot more staff and it's about four or five hours a day per resident for Alzheimer's.

MS HART: Just following on from that, the accountability that would necessarily be part of contractual funding; does that cause you concerns?

MR. STEVENS: No.

MS HART: One other area, and perhaps I could deal with Mr. Nightingale on this: You made a comment that I wanted to pursue. You said that you were in agreement with some of Mr. Cooke's comments about the revocation process. Could you elaborate on that for me, please?

MR. NIGHTINGALE: I was referring, Mr. Chairman, to the concept of when people are not complying with the regulations, why doesn't government act more quickly, if I recall the tone of the discussion this morning.

And very simply, where people are not living to the regulations, government should act appropriately, depending on what the circumstances are. Well, let's establish the same 458 regulations governing nursing homes, fire safety, environment, statute, all longterm. What we are suggesting, Mr. Chairman, is one set of rules for

everybody.

What Mr. Cooke, if I might, what Mr. Cooke did not say is that when we had problems with Green Acres Home for the Aged, major, major problems with public reporting, or Centennial Manor in Peel with devastating conditions reported. Reading Hansard I never really saw anyone saying, "revoke the license and start prosecutions against the community or the person holding the license."

And I am not defending nursing homes versus any other group. I am simply coming back to, there will be good and less good in all categories. And what we really have to do to ensure uniformity and universality and protection for the public is simply have everything we propose to do here apply to every extended care facility so that everybody's protected the same way.

MS HART: Can I deal with you just for a moment on the revocation process?

Philosophically, are you in agreement with Mr. Cooke, that there should be no opportunity given for compliance, that if there is a minor infraction, that there should be immediate prosecution? I need you to elaborate a little bit on that.

MR. NIGHTINGALE: I'm glad you asked. Very simply, we use two words very loosely. One is called "violation"; one is area of "non-compliance".

Under the 458 regulations, some people choose to say that if it isn't right that way, you are in violation and therefore the police should come, haul you off to jail and be arrested. Another way of looking at it is, that if you have not been in total compliance, you should have an opportunity to comply.

Let me give you some for instances:
Fire..."separation doors" is the proper term, between wings of a nursing home; some staff, to move quickly from one side to another, may put a door jamb under the fire separation door or an ashtray to hold the door open. That is an area of "non-compliance", or if you want to take the other side, a "violation".

Management, when it receives certain types of these types of things, will try and tell people don't do these things, and has to submit to Mr. Sapsford, in all the areas of non-compliance, what they are going to do to comply. He indicates us to take more supervision of the staff, or whatever the case may be.

There are other instances, Mr. Chairman, where some of the instances are more serious. Okay? And that's a

judgmental call by the Ministry on how it will enter into the means of forcing that person to meet the regulation. I am not an apologist for the Ministry, but I understand the difficulty. Sometimes there is a lot of nebulous stuff, and there is some very serious stuff in those regulations. And since the Ministry is responsible for enforcing its own Act and Regulations, they have to make the value judgment whether they ought to give somebody the opportunity to comply, or to go right in and prosecute.

And frankly, it's their problem, but it is a difficult one and it does affect people. And so, without having the very specific facts before me, Mr. Chairman, I can understand a very good argument to force, to allow people to comply, because there are a lot of sections.....

Wallboards, people -- the wheelchairs: if you knew how many wheelchairs are in the nursing homes and the damage they do to walls, and you can just finish re-walling, filling the drywall, and repainting and they come out in their wheelchairs and destroy the place. And the inspector walks in and he says, "Look at that. I'll give you a chance to comply." Well, there are certain things common sense says yes, fix it up and comply and give us your compliance plan again, and then others, Mr. Chairman, where they are more serious.

So I understand the dilemma and I don't have the answer. But I don't think there is any one answer, to be perfectly frank.

MS HART: One other area, just following on from that, and perhaps I could have your comments on. One of the reasons why the process is extended is really due process, the fact that owners or licensees have the right to appeal and to pursue that avenue. Do I take from what you say that you would like to remove that due process in order to speed up the process?

MR. NIGHTINGALE: No. But what I am saying, Mr. Chairman, is that under the proposed amendments, the proposed amendments are calling for the repealing -- I'm going by memory here -- of Section 11, which states that before the Minister can revoke a license or take over a nursing home, he has to go to the High Court to get permission to do so. And the High Court normally would ask for, has the respondent been given notice, et cetera. By repealing that, the Ministry is relying solely then upon the Special Health Facilities Act.

We are going to be suggesting that a person still ought to go to court to get from the court permission to take over a facility, because we do have fear about natural rights and natural justice. We have seen other cases not quite too dissimilar to this where the end result is that

people were destroyed and nothing was proved anyway. And so we still don't want to throw away the natural process, natural rights or due process, if you like, the same way employees of the nursing home wouldn't want to give away their rights under these proposed amendments or under the Act, or under any labour act.

So we think there ought to be a process that allows for fairness, due process, but still in a timeframe that the Minister can, where the Minister feels the health welfare and safety of the resident is jeopardized to act in a prudent way to hold itself accountable publicly for taking such action and to the court.

MS. HART: So we are looking for that ideal balance. Thank you, sir.

MR. STEVENS: If I may. I think we have to remember that this is Ontario, Canada. This is a free country where we have fought wars and come back to basic freedoms and basic rights, and that's for everybody. And sometimes I think, when we look at the Health Facilities Act, I think I am in a different country and a different time, a place that's removed the rights of individuals.

That may be fair ballpark, fair game, the process about being concerned about residents. But if you start to put our ability to mortgage our facilities in jeopardy, if you start to get so sensitive with licenses and license hearings and license approvals, and hold up to license approvals on transfer for some conditions being met, that in essence you might take the whole industry and we may no longer be able to raise the capital dollars you require from us.

And there are millions and millions and millions of dollars government requires each year raised by our industry to pay for our facilities. If the mortgage market won't go along with us, then we can't raise those funds on your behalf or a resident's behalf. It's all done. So the license becomes a significant part of the process and can't be in such absolute jeopardy day after day after day that they won't fund it.

MR. CHAIRMAN: Mr. Cooke.

MR. COOKE: Thank you, Mr. Chairman. I just have a couple of other questions, one I would just like to suggest to Miss Hart: that she might want to review what I said this morning, and she might want to review the history of Country Place. These were not minor violations of the Nursing Home Act. Restorative care, dirty kitchens, lack of staffing are hardly minor violations of the Act.

And I agree with what Mr. Nightingale is saying: if

it's an ashtray that's holding up a fire door, I am not suggesting that the nursing home should be taken over. But if somebody is not getting therapeutic diets, not getting restorative care, or a kitchen is dirty that could potentially lead to a tragedy like we had in London where nineteen people died, you might in fact think that those are more major and not something that should be subject to a four year process, as has been the case in the Country Place violations.

I have had the opportunity of looking at a couple of other things in your brief. On page 25, you refer to: Upon receiving the report -- and this is dealing with section 17 A-1, which is a report of possible abuse or suspecting a resident has suffered or may suffer harm:

...that it's your feeling that the nursing home itself should be involved in the investigation when there is a report to the director?

MR. NIGHTINGALE: Very well may be, Mr. Chairman, very simply because if it's a section dealing with harm to a resident, the licensee has a responsibility to protect other residents. And if there is an investigation under way or a major complaint along that way, from my point of view, it's only common sense to have the home notified to have extra supervisory staff, or have the staff that are there, increase their supervision.

MR. COOKE: You are not suggesting that you would conduct the investigation; you are suggesting that you would be party to and obviously would be one of the people that would be interviewed and ---

MR. NIGHTINGALE: Exactly.

MR. COOKE: All right.

Under the next point that you make, I am not quite sure if you understand the ramifications of potentially what your suggestion could do, and that suggestion, of course, is that in addition to saying that any person who acts maliciously or without reasonable grounds, that they shouldn't make those reports but that they're subject to these ten thousand dollar fines, or potentially ten thousand dollars fines.

Are you not concerned that if you build this kind of thing into the legislation, that people who have information -- and I'm talking about legitimate information -- are going to be very reluctant to make any reports because of fear that they might be tied up in some court proceedings with an owner of a nursing home?

MR. NIGHTINGALE: Well, Mr. Chairman, we looked at it from a different angle, if you like. The whole aspect has been holding the owner or the licensee accountable. That's the whole basis throughout the process. We have no problem with that, as long as there is a degree of balance in fairness to it.

Similarly, we expect that where anybody making a false report or a malicious report, untruth, the Act does not say -- the Act says you shouldn't do it. The Act does not say that if you do do it, it is punishable by the terms of this Act. And so what we have put in here is, very simply, that where people knowingly and maliciously report false information to the director, it is a punishable offence.

MR. COOKE: If that was easily determined, I wouldn't necessarily disagree with you, but you are assuming it's a black and white issue. What I am suggesting is obviously a person who makes a legitimate complaint and that there is an owner of a nursing home who decides to harrass that person by saying, "Okay. I am going to take action against you and file a complaint that you have violated that section of the Nursing Home Act."

That then one example of that in the whole province, all there would need to be is one example where that occurred and publicity ensued and it would be a disincentive for anyone to ever make a report again. And obviously the purpose of this section, the entire purpose of this section, is to get people who have knowledge to report. Shouldn't we err on the side that we are going to get the reports of the legitimate complaints rather than build in disincentives to have legitimate complaints?

MR. NIGHTINGALE: Of course. And aren't we also not to protect the licensee from malicious or false reporting?

MR. COOKE: We are there to protect the residents.

MR. NIGHTINGALE: That's right. And the Ministry knows that -- how do I say this politely? Well, let's be open.

I understand Mr. Cooke's argument, Mr. Chairman. There are times during the course of a year where there may be contractual negotiations going on and the Inspections Branch receive a higher frequency, perhaps, track of complaints.

One could argue -- we'll really make it black and white -- one could argue that's because negotiations aren't going well and somebody called the nursing home and the inspector causes the nursing home owners some aggravation.

That's a black and white scenario.

I am saying we have had and gone on for too long with many accusations being thrown about that have turned out to be false, or untrue. And people's names have been besmurfed in the community unfairly, where they were going to go into legal process and the Crown has decided to drop those charges. Things cool off, but the name still sticks there.

We are saying look, if you allow people to make complaints, what the legislation does, it puts an onus to report harm. It also, through the proposed amendments, says the law will protect you against anybody trying to coerce you from not taking action.

MR. COOKE: I understand your fear. The same fear was expressed when the Legislature was dealing with Bill 70 and giving employees the right to refuse work that they considered to be unsafe. Employers came before a Legislative Committee and said that that would be used during contract negotiations and it would be used by disgruntled employees and that there should be this test of whether it's legitimate or illegitimate. If it's illegitimate, the employee could be subject to being fired.

The Legislature decided to go on the side of encouraging workers who considered their work environment to be unsafe to be given the right to refuse without the fear of reprisals. And as it turns out, it's not a major problem in the work place. People are not abusing that section. They are using it. And then there is the investigation that takes place as a result. I think you have to really err on the side of encouraging the report. Otherwise, you are not going to get the people to make the reports, just as we had to do as well on the child welfare legislation.

MR. NIGHTINGALE: Mr. Chairman, I think what it comes down to is reasonable grounds, and that may be something you can look at.

MR. STEVENS: I just want to say, the fact is that we are only suggesting here that it is without reasonable grounds that anything would happen. We are also suggesting that the nursing home owner would not be the one who is prosecuting, but the system, and that I would see it very similar to somebody who maliciously pulls fire alarms or reports bombs aboard airplanes. I mean, we want everybody to pull a fire alarm if there is a fire. We don't want somebody pulling it without a fire.

MR. COOKE: I am quite sure there is an analogy.

On page twenty-eight, you are making comments about

that -- what basically you are saying is that there is a transfer of power from the Inspections Branch or from the Ministry to I guess residents councils. And I don't know if you want to expand any further on that. I certainly share some of that concern and I hope that we will be able to somehow strike a balance, recognizing that there is a role for the residents to play in the nursing homes, but there is also.... I don't think that we want to have the residents.... We want to empower the residents, but we don't want to put them in the position where they are enforcing the Act.

And I am not quite sure -- I haven't figured out in my own mind what that balance is. I've talked to residents council people and advocates for seniors, and I think the community, the advocates are split as well on this whole issue.

MR. NIGHTINGALE: Mr. Chairman, I think if Mr. Cooke and I keep agreeing, I may want to revise my entire submission.

MR. COOKE: This is only twice.

MR. NIGHTINGALE: We understand, and I think there is a common ground here. We are working, over the last few years, to build up residents councils, residents council guidelines, and have them active where possible. And we agree with you, we didn't want to see the residents council composed of the type of people we described having to enforce the law. That is just not what it was intended to do or be. We don't have a full answer here, with the exception of that that whole concept of advisory committees, we've stated in our brief, is neither fish nor fowl. It's not an advocacy system; it's not a complaint system.

Frankly, we can find pages and pages of things that are wrong with it. So what we are suggesting to the House, rather than being negative about it, is saying, "Look, there is another way of dealing with it in a more professional way and accountable way." And that's basically a complaint system, a complaint, independent complaint board that can deal with the residents council if they call them in, or any citizen calling them in, and deal with them. Either resolve it with that person and have the resolution posted, or if that can't be achieved, then at the very least to have a total investigation and make a public report to the Minister.

MR. COOKE: We agree with our concerns but we might not agree on our solutions.

MR. NIGHTINGALE: I understand.

MR. CHAIRMAN: I am marking that one down too, Mr. Cooke.

MR. COOKE: Well, I think my leader was around the corner, so I was hoping he heard that.

MR. CHAIRMAN: Mr. Reycraft.

MR. REYCRAFT: Thank you, Mr. Chairman.

Mr. Nightingale, in your presentation you made reference to the classification system that exists in some of the western provinces. Could you tell us a bit more about that? I'm not familiar with it.

MR. NIGHTINGALE: It's fairly detailed, Mr. Chairman, but really what it states -- I am using layman's language -- that people who, residential type of person who walks and doesn't need medical care that much, except they may need some medical care within the building; then you move into your intermediate, you get into your medium to heavy people who may require between two-and-a-half to four hours of care; and then there is the top end of the spectrum of four hours of care.

And all those levels are very clearly defined with some assessment tools behind them to show how you get them. And it's...I have no other way of explaining it except, assessments tied to a certain level based upon a certain level. Based upon that level, this is the type of care you are to receive. And based upon that type of care you receive, here is the money that is supposed to be in place to make sure you get it.

MR. STEVENS: If I might just explain a bit more, in Manitoba they have a three or four tier system, and what I know about it is the fact that once a year they do an assessment of the patients in the facility. They assess in the ranges of one-and-a-half to two hours, two-and-a-half, et cetera, and that sets the pattern for the home for the next twelve months.

So they assume if somebody leaves the home, that they will re-admit somebody to the relatively same level of care as the one who has left, so there is a constant balance. They funded the various levels of care at a very differential rate, so that a person who requires four hours of care gets a different rate than somebody who requires an hour-and-a-half of care. And they expect you to staff based upon this mix of funding.

So that they will look at a hundred bed home, come up with thirty, thirty, thirty and forty, multiply up the staffing, multiply up the rates, and that's it for the year.

Now, throughout the year, of course, it changes. You know, people get heavier, people move in, and it sort of mixes and matches. One year later they come back. And this information is available to the P.C.S. so they're aware of what type of mix you have and what type of levels of care you have, and they try to admit people to your home that require the care that you have available to them.

This stops the imbalance that we have in our home where you have two hours of care in our home provided and somebody comes in that requires three hours. Well, for us to provide that person with three hours, we steal an hour from somebody else. That's how the process works. That's how it worked in 1970 when the program was designed. That's how it was meant to work. That was the foundation of our whole process. It's still in place. Our system's all changed around.

MR. CHAIRMAN: Who does the classifying in those situations?

MR. STEVENS: I understand that there is a group, the Ministry and/or the advisory physician, or a mixture thereof, but it's not the people in the nursing homes. Somebody comes in and does it.

MR. CHAIRMAN: We may be able to get a hold of a document which compares and contrasts the various provincial jurisdictions and the way they deal with longterm care for the elderly, and that may be useful to us. The Minister is going to try to obtain that for us. He may have some of that information for us.

MR. REYCRAFT: Just one further question:

Do I understand then that it's based on a once a year snapshot of the amount of care that's being provided in a home, and the funding for the year is based on the levels of care being provided to various patients at that time, whether it changes or not throughout the year?

MR. STEVENS: That's our understanding from the Manitoba model. Other models are built where they are assessed more often where the care funding is changed accordingly. There is even a concept of using computers where you can do an instantaneous upgrading using the admission criteria and the three to six month assessments that doctors already make of our patients. But that would be a more complex thing and is a drag in funding, all of which has been investigated by many people in many jurisdictions around North America.

But the problem of funding, appropriate funding for longterm care patients, happens in fifty-two states in the United States and ten provinces in Canada, and there are

books and books written about it.

MR. COOKE: A different question, Mr. Chairman:

I am aware that whenever nursing homes or beds change hands from one operator to another, there is a value, of course, attached to the beds. And my impression is that that value has been steadily increasing and is now somewhere in the neighborhood of \$30,000 to \$35,000. I guess the first question is, is that the case?

MR. STEVENS: Mr. Chairman, the value's in the building, not necessarily in the beds. The cost to build a new nursing home bed today is about \$40,000. That doesn't have any value in the license whatsoever. The value is not in the license at all. The value is in the building and the structure.

Now, occasionally a license is purchased. "Purchased"; that's a misnomer because it's a tri-angular arrangement between making a deal with the person who owns the license to obtain it, if the Ministry awards it. But it does happen. Sometimes licenses are now going between five and ten thousand dollars a bed. But only those people who can build onto an existing facility, just like the farmer who buys the farm next door at a price too high because he wants to have the efficiency of two farms. But there are no trading of licenses today, just with that one circumstance.

MR. COOKE: Could I ask something:

The two nursing homes in Southwestern Ontario that you might be familiar with, the sale of Westhaven in St. Thomas to Crescent Care, and the sale of the home in Tavistock to Crescent Care. In neither case was it proposed that the existing facilities would be the nursing home. The purchase was that of the license where one might even say -- and the beds, but not the physical structure because they are moving -- one might even say that the purchase was of the license and a cash-flow at a value of between thirty and thirty-five thousand dollars a bed.

MR. STEVENS: Mr. Chairman, that is not correct. The owners in both cases are keeping the buildings. He bought the building and the license, and in both cases, he is maintaining the buildings, not as a nursing home, but as a retirement home.

MR. COOKE: That's what I mean: they are changing. They are moving the nursing home residence to another nursing home.

MR. STEVENS: But he still owns the building and the building is what he paid the money for.

MR. COOKE: The other example is in Ridgetown, Barnwell Nursing Home.

MR. STEVENS: I am somewhat familiar with that since I was the one who did that.

MR. COOKE: Well, maybe we could get the details on that sale.

MR. STEVENS: Do you wish it, sir?

MR. CHAIRMAN: Are you asking for them?

MR. COOKE: Sure. I'd love to have some of that information filed with the committee on the sale of that home.

MR. STEVENS: The owner of that nursing home, Mr. Barnwell, was informed by the Ministry of Health that they were going to close his nursing home if he either rebuilt or sold. He got that in writing. And he came home and he phoned me up and said, "Would you like to buy my nursing home?" I said, "I would like to buy your nursing home if and only if I could move the license to Chatham."

We proceeded through the appropriate channels, both through the Health Council and through the Ministry of Health, and we were approved to purchase that home by moving the license to Chatham.

We proceeded to buy the home. We proceeded to build a new wing on our Chatham nursing home and proceeded to move the residence to a fine nursing home that's provided high quality care in a fully accredited establishment, and we looked after the people.

We went back to the Town of Ridgetown. We reopened the home as a retirement home and we tried to employ as many people as possible. I might add that everybody who worked for me in Ridgetown got a job either in Chatham or in Ridgetown, if they so wished. So we looked after our families and our residents -- no, I'm sorry, not the families; the residents and the employees. I don't believe we did a very good job looking after the families because their consequence is they had to drive fifteen miles to Chatham to see their loved ones. That was not my choice.

The home was going to be closed by the Ministry. So by making the decision to close the home, and in 1980, nobody could afford to build a thirty-seven bed nursing home free standing in a small town. So it was not possible, is not possible. And so in essence, I responded according to my contract with the purchaser and my contract with the Ministry.

The fact is that the process probably left out of the equation the town of Ridgetown. And I guess it's up to this government to make up its mind whether or not it wants homes in small towns. And if it does, they are going to have to come up with some economic way of being able to afford them.

MR. COOKE: I think there is a question also, when a sale like that occurs, as to who has a right to be consulted? Do the residents have a right to be consulted? Do the relatives and the community have a right to be consulted? None of that was done in the Barnwell case.

MR. STEVENS: Sir, when that sale went through, I approached every body that was supposed to be approached, as we were instructed. If this body here decides that more people are to be consulted, then so be it. But to look back five years and question a deal that went on at that time is probably totally irrelevant.

If you wish relatives to be consulted, then I would ask you sincerely to ask in your heart, what is their real objection? Is their objection the fact that they don't want their loved ones to be in a better nursing home? Or is their objection the fact that they're too lazy to drive fifteen miles to see them?

MR. COOKE: Well, that's a great approach.

MR. CHAIRMAN: Mr. Reycraft.

MR. REYCRAFT: Just to go back to my question, I gather then the value of the beds, if the license was being transferred, in your opinion, Mr. Nightingale, is the five to seven thousand dollars, not the thirty to thirty-five to which I referred? Did I understand you to say that?

MR. NIGHTINGALE: I said that, sir.

MR. REYCRAFT: Sorry. So five to seven thousand dollars. Okay. Thank you.

MR. CHAIRMAN: Mr. Andrewes.

MR. ANDREWES: Briefly, Mr. Chairman, I want to come back to the whole subject of the residents council advisory committee, and more particularly, the residents council advisor, and perhaps to ask Miss Hart's guidance on what the Ministry perceived as the qualification for the residents council advisor?

MS HART: It was intended those people would have the type of qualifications that that home needed, or that regional group of homes needed. It was not intended that

they be doctors or lawyers, it is my understanding. It contemplated that the needs will be different for different homes. Some may require more financial advice; others may require different fields of expertise. If you set it down that they must have this or that qualification, you are limiting yourselves. And it's my understanding that that's why it has been left open.

MR. ANDREWES: When we had the briefing prior to the introduction of this Bill, we were told by Ministry staff that perhaps the residents council advisor perhaps might be a retired accountant who now lives in the community and could devote part-time service to this job. Is that the concept that is consistent with what you say?

MS HART: I would like to refer that to Mr. Sapsford, who has something to add.

MR. CHAIRMAN: Mr. Sapsford.

MR. SAPSFORD: Thank you, Mr. Chairman.

Following along on the discussion, we did not want to specify specific qualifications, as Miss Hart has outlined. The concept of the advisor is to provide support to the committee in the home. Part of the problem in dealing with residents councils, or part of the problem that residents councils have, is that this group of residents have difficulty getting information, finding out information, doing leg work, involving people from the community.

So the ideal is to provide some full-time approach to giving residents advisory committees hands and feet to do so some of the work in the interests of the committee. Whether these people have professional qualifications I suppose is a consideration, but certainly wanted someone who had some administrative skills, someone who had knowledge of the care field itself, someone who is able to communicate well, someone who has some appreciation for the difficulty that people in institutions and some of the concerns that residents would have in terms of how the program would operate.

It was felt that a full-time person could serve the needs of several nursing homes perhaps, and that the residents council advisor could bring to the committee and the home not only an external view, but also could begin to share information between nursing home councils so that gradually they would be able to help each other, not only in terms of the individual home, but also in terms of homes across the province.

I think some question was raised with whether the Ministry would be involved in this, and thinking that this

point is that the system of advisors would be operated on a provincial basis by an external group, and that it would be a provincial based organization, charitable, nonprofit, that would be responsible for the operation of the program, responsible for the hiring, and that the funding of it would be transferred to this type of group by the Ministry of Health.

Doing it this way would begin to provide not just an individual home perspective, but would begin to provide a provincial perspective to residents councils, to advisory committees, and to the standards of this type of program across the province.

MR. CHAIRMAN: Mr. Andrewes?

MR. ANDREWES: Is it fair to say that the residents council advisor by any other name is called the residents advocate?

MR. SAPSFORD. No.

MR. ANDREWES: Why not?

MS HART: It's not intended at all that this person or persons would be an advocate for the rights of individual residents. That's a whole separate topic which is not inconsistent with residents councils, but will have to await the work of Father O'Sullivan to deal with the advocacy for individual residents. The residents councils are intended to look at the operation of the home as a whole.

And if I might give you an example of what Mr. Sapsford is talking about, a nonprofit organization that currently does something like this would be the Ontario Cancer Institute which runs at Princess Margaret.

MR. ANDREWES: But I guess my difficulty here is that you are suggesting that there will be a system of advisors, province wide, and operated by an external group, independently funded from the Ministry, at least funded but operating independent from the Ministry, with very extensive powers. The advisors who were instructed by the committee to make an inspection may enter the premises, are entitled to free access of all the books of account, documents, bank accounts, vouchers, correspondence and records, including payroll records, records of staff hours worked, medical and drug records, and any other records that are relevant for the purpose of inspection or required to be kept under the Act or the Regulations. The qualifications of this individual, so far as I can see, are equal to or probably exceeding those of an inspector.

MS HART: I would take issue with you that they

exceed the powers of the inspector.

MR. ANDREWES: Does an inspector have powers to examine the drug and medical records?

MS HART: I believe, yes.

MR. ANDREWES: Does the inspector have the power to examine all the books of account, document, bank accounts, vouchers, correspondence and records ---

MS HART: Yes.

MR. ANDREWES: -- kept for individual residents?

MR. SAPSFORD: Yes.

MR. ANDREWES: Yes?.

MR. SAPSFORD: Yes.

MR. ANDREWES: Well then, the power is equal to an inspector; is that fair to say?

MS HART: I haven't gone through it power by power, but I would agree with you that they're not insubstantial.

MR. ANDREWES: So we are going to have an externally funded, externally operated, province wide system of advisors who are going to be checking up on the inspectors.

MR. DAVIS: It's the policy of the government to have all kinds of....

MR. ANDREWES: Is that true?

MS HART: No, it is not true. Mr. Sapsford wishes to add something.

MR. SAPSFORD: The question is focussed on the advisor, and I think I'd like to draw attention to the fact that the advisor is directly responsible to the advisory committee, to the residents and the people who are involved in the home.

The powers of any advisor come directly from the advisory committee. I think the principle involved in the advisory committee is to begin to involve the community. One of the problems that is apparent in the nursing homes, at least in some cases, they're isolated institutions, and as hospitals in the province have significant community input, the principle of the advisory committee, in terms of membership, is to begin to draw into the nursing home significant community participation on behalf of the residents. So that the focus of the advisory structure,

the residents council structure, is not so much the advisor but rather the committee and the relationship between the committee and the advisor.

MR. CHAIRMAN: Mr. Andrewes?

MR. ANDREWES: I think my questions are answered, Mr. Chairman.

The point of my concern is that I think you have got clearly a duplication in the role here, and I am not sure that it's an appropriate role to be delegating to a residents council.

MR. CHAIRMAN: We'll be hearing more about this.

MR. ANDREWES: I am sure.

MR. CHAIRMAN: Mr. Cordiano had a question.

MR. CORDIANO: Just to follow up on that line of question, would it be fair to say that an inspector, the difference between an inspector and what an advisor's role might be is that simply an inspector would follow up with enforcement and would have to make decisions pertaining to enforcement of contraventions and would be dealing directly with the Ministry officials in reporting whatever contraventions there might be, whereas what you envision for, or at least what I see happening for an advisor, is working with an advisory committee and instructing that committee with regard to the operations of the home and comparing operations within that home to another home which that advisor might be subsequently, or it may have two or three homes, which I think is the role of the advisor, maybe attached two or three or four homes -- I don't know how many you might specify, and I don't know it's clear here -- but I would think that that's a partial difference that you could make between an inspector and an advisor in the capacity that that person serves?

MR. SAPSFORD: Yes, I would agree with that.

The advisor has no role in enforcement; nor does the advisory committee as it's contemplated here in the amendment.

I return to the concept of drawing the community into the home. The advisory committee and residents councils' concerns deal more with the programs in the home. We anticipate that this kind of a group will begin to draw volunteers into homes, will provide the contact between the nursing home and other networks in the community, that their concerns will revolve around programs and activities in the home, rather than marching through the home looking for violations of the Nursing Homes Act. That's probably

the role of the inspection, and that role does not change.

It's the focus of the residents council advisory committee advisor to deal more with the general operation of the home, to begin to provide a community atmosphere, and the powers of the advisor are simply to allow the residents, through the committee, access to the information that they need to evaluate their living environment, their home, and to be able to form opinions and make recommendations to the administration, the licensee, or even the Ministry, on ways that they can improve their home.

MR. CHAIRMAN: I think Mr. Johnson wanted to add something. Did you, Mr. Johnson?

MR. JOHNSON: I think it was supposed to have been covered, sir. I guess I would put it this way: that the powers, while they are fairly considerable, of the advisor, are in a sense voluntary and are in no way a replacement of the obligations of the director through his inspectors to do their thing: to inspect, report, obtain compliance, et cetera. The committee may well choose not to exercise those powers. They would be under no obligation to.

MR. CORDIANO: In order for action to be taken, you would still have to have an investigation of whatever matter is being considered a violation. You would still have to have an inspection take place of that home, and whatever mechanism is in place for that, that would still have to take place. Regardless of what the advisor may come up with and that advisory committee may come up with in terms of recommendations, or even as a report to the director, you still would have to have an investigation conducted by that particular inspector for that home?

MR. SAPSFORD: Yes.

MR. CHAIRMAN: Thank you, Mr. Cordiano.

Are there other members on my list that either Mr. Nightingale or Mr. Stevens would like to say anything further to as we wrap up for today?

MR. NIGHTINGALE: I would just like to say that I would like the committee to consider my request, that once the amendments have been stacked and voted upon, that I be given an opportunity to present some closing remarks, if that's the committee's wish?

MR. CHAIRMAN: I think what we will probably decide is that, either in a procedural vote of the committee or through the steering committee, what we'll do, and as we have, through some of the other bills that we've dealt with in the last year or two, allowed some of the major players

to...not have standing before the committee during clause by clause, but to come back to us at the time that amendments were being made so that they could make some final comments on it. I imagine there would be a predisposition to do that. I will clear it up with the committee as we move along, and you will be aware of that because you will be auditing. Thank you both.

Oh. Mr. Cooke, on that matter?

MR. COOKE: If we are going to do this -- and I'm not sure; I'm just beginning to work through the process of drafting some of the admendments that we want to propose -- but when we did the drug bills, we tried to have our amendment in by such a date so that the interest groups could take a look at amendments that all three parties were going to be proposing, and then they reacted to the amendments.

That's going to be difficult, but that would be the ideal. Otherwise, I am not sure what you are going to react to if you haven't seen our amendments.

MR. CHAIRMAN: I think the difficulty will be, and our time a lot of this time, what we tried to promise that to one -- I forget which one of the bills we were dealing with -- and it really proved to be very, very difficult to do -- the drug bills, as I recall.

And if you are auditing it, you will start to gather an idea of where people are going, and you obviously have access to the members in terms of talking about what kind of amendments they may be coming up with and then have a chance to be slightly more prepared than maybe some of the other groups would be.

But it looks like we will be giving an opportunity like that. I'm just not sure how much advance notice you are going to get of the actual amendments, and that may be a logistical problem.

MR. NIGHTINGALE: Thank you.

MR. STEVENS: Thank you very much.

MR. NIGHTINGALE: Thank you

MR. CHAIRMAN: I have some news on the question about tomorrow.

The Concerned Friends were willing to be put over tomorrow and not come in. They would like, however, to table with us their documents, so that would be quite helpful to us to have that well in advance, and we advised them that if they want to have a supplementary document

afterwards when they appeared, that would be fine.

They will appear next Wednesday morning. So tomorrow afternoon there will be the Minister of Health here.

MR. DAVIS: Tomorrow?

MR. CHAIRMAN: That's Thursday tomorrow. I know you are in a bit of a rush to get back to the pulpit on Sunday, but it's only Wednesday.

So what we will basically do, I would presume, would be to talk about the bills as they exist at the moment, any response you might have to the opening statement that has already been made, and direct that to the Minister rather than to the Parliamentary Assistant, and any other matter that you might wish for tomorrow afternoon. We've scheduled nothing else, not knowing how long that will take. That kind of an event is always so unpredictable, in terms of the time.

Mr. Andrewes?

MR. ANDREWES: Mr. Chairman, I have two brief questions: First of all, I believe this room is locked when we leave, is it? Material left here can be left here ---

MR. CHAIRMAN: Material can be left here overnight.

MR. ANDREWES: The second question is, that it appears that now we are going to end the delegation next Wednesday....

MR. CHAIRMAN: It looks very likely.

MR. ANDREWES: ...and so Thursday we'll start on clause by clause?

MR. CHAIRMAN: I think that would be my presupposition at this point. If there is a logistical problem with that, one of the options would be to give ourselves a longer weekend for drafting, if that becomes an issue for you, and if you can let me know that as early as possible next week, then we can make that decision. Otherwise, I presume we will go onto clause by clause on Thursday.

MR. COOKE: We should raise this more than the amendments. Amendments are going to be hard for next Thursday.

MR. CHAIRMAN: If it is a difficulty, it is an option just to skip the Thursday and to come back on the

following Monday, which would give legal counsel who are working for all of you a chance to draft the amendments.

MR. ANDREWES: Thank you.

MR. CHAIRMAN: Anything further?

We are adjourned until tomorrow morning.

The Committee adjourned at 4:10 p.m.

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STANDING COMMITTEE ON SOCIAL DEVELOPMENT

NURSING HOMES AMENDMENT ACT

HEALTH FACILITIES SPECIAL ORDERS AMENDMENT ACT

THURSDAY, FEBRUARY 19, 1987

Morning Sitting



STANDING COMMITTEE ON SOCIAL DEVELOPMENT

CHAIRMAN: Johnston, R. F. (Scarborough West NDP)
VICE-CHAIRMAN: Allen, R. (Hamilton West NDP)
Andrewes, P. W. (Lincoln PC)
Baetz, R. C. (Ottawa West PC)
Callahan, R. V. (Brampton L)
Cooke, D. S. (Windsor-Riverside NDP)
Cordiano, J. (Downsview L)
Cousens, W. D. (York Centre PC)
Hart, C. E. (York East L)
Jackson, C. (Burlington South PC)
Reycraft, D. R. (Middlesex L)

Substitutions:

Davis, W. C. (Scarborough Centre PC) for Mr. Cousens
Newman, B. (Windsor-Walkerville L) for Mr. Callahan

Also taking part:

Hart, C. E., Parliamentary Assistant to the Minister of Health
(York East L)
Ramsay, D. (Timiskaming L)

Clerk: Carrozza, F.

Witnesses:

From the Ministry of Health:

Johnson, J. M., Director, Legal Services Branch
Sapsford, R. T., Director, Nursing Homes Branch

From the United Senior Citizens of Ontario:

King, J., President
Mansfield, A., First Vice-President

From the Canadian Pensioners Concerned Inc.:

Woodsworth, J., President, Ontario Division

From the Christian Labour Association of Canada:

Beekhuis, H.
Kuntz, H.

LEGISLATIVE ASSEMBLY OF ONTARIO
STANDING COMMITTEE ON SOCIAL DEVELOPMENT
Thursday, February 19, 1987.

The Committee met at 10:15 a.m. in Room 2.

MR. CHAIRMAN: I call the meeting to order, seeing a quorum. I also recognize that there is a pretty sparse turn-out at the moment, and as more members are here in the morning, I think I will indicate it will be my preference from this point on, so that we are not insulting our guests as we hold public hearings, that I will start at five minutes past the hour that is established to meet, whether or not there is a quorum. Otherwise, those people have the right to be heard when we said we would hear them.

And this morning our first guests are the United Senior Citizens of Ontario. And I will ask Miss King to come forward, with support or alone, however you'd like, and take a seat in front of me here.

I just say, Mr. Davis, that we are going to have to go back to what we did under Social Development, Bill 30, and that is that we are going to have to understand that we have to start promptly for our guests, and therefore I am going to now start at five minutes past the hour, whether there is a quorum or not. If you could pass it on to them, that would be fabulous.

MR. DAVIS: I'm not the Chairman of this committee.

MR. CHAIRMAN: I understand.

Mrs. King, would you care to introduce your guest? You have been before the committee before so you understand that you can give your presentation in full, anyway you would like, and then we'll open it up to questions following.

MRS. KING: Fine. The person I have with me is my First Vice President of the United Senior Citizens of Ontario, Mr. Alec Mansfield. I think most of you know who I am: I am Joyce King, President of the United Senior Citizens of Ontario.

Our presentation will be rather brief because we support Mr. Elston in the amendments. We almost have to because many of them were in the brief that we sent to the government, and he has included practically all of the things that we brought forward as necessary for changes to the Nursing Home Act.

If I may, I know you all have a copy of the brief statement, but if I may read it?

MR. CHAIRMAN: Please. That's the way to get it on the record.

MRS. KING: Right. The United Senior Citizens of Ontario Incorporated approves in principle the amendments the Nursing Home act. Many of the concerns expressed in our brief to the Ontario Legislature have been included in the amendments.

We are, however, concerned as to how these amendments will be enforced. It's fine to say that any resident, family member or friend may voice a complaint without fear of reprisal, but how will the Ministry ensure that this will happen? We must remember that we are dealing, for the most part, with the frail elderly, most of whom would not be in a nursing home if they had an alternative, and many of the residents will not have a family member or a friend to support them.

I am sure the Nursing Home Act now in force covers many of the principles contained in the amendments, and yet in some existing homes, these principles are not being enforced. We know that many residents in nursing homes are being over medicated, in some instances merely to keep them quiet, and to our organization, this is unacceptable.

We agree with Mr. Elston that each resident should receive a copy of the principles of the Nursing Home Act, but we still have our concerns about the enforcement of these principles. The inclusion of a residents council is, in our opinion, a forward step. The Act states a residents council will be established whenever at least three persons who are either residents of the nursing home, or representatives of residents, shall request such a council. What of the nursing homes where such a request is not made?

We applaud the Minister for the inclusion of such residents councils because we certainly believe the residents should have input into the operation of the home in which they reside. We do feel that the establishment of an independent committee comprised of people living in the area in which the nursing home is located is vital to the success of the residents council.

We are very concerned with the granting of licenses to operate a nursing home to anyone without a very thorough investigation into the reputations, past performances and character of the applicants for such licenses.

If I might digress, when we spoke to Mr. Elston about this, he assured us that the thorough investigations would now take place. Because we do know of instances where people have come into Ontario, applied for a license for a nursing home, that have had a very bad reputation in

other countries. We do know there are some very good and well run nursing homes in the Province of Ontario, but we are also aware of many which are not fit for elderly residents. From personal observations, we know of many homes which would not pass any of the criteria expressed in the Nursing Home Act. It is our hope that the amendments to the Nursing Home Act will force these homes out of existence if they do not comply with all the rules set out in the Act.

The United Senior Citizens of Ontario believes that the ideal situation would be no run-for-profit nursing homes. We believe when there is a profit motive, corners may be cut to ensure that profit. We agree with the amendment which will require licensees to post financial statements. If this situation cannot be achieved, then the Ontario government has an obligation to ensure that the elderly residents of nursing homes in Ontario are given the quality of life to which they are entitled.

In conclusion, we wish to comment the Minister of Health for his many hours of consultation with us. The best source of information on the needs of senior citizens is the seniors themselves. This is true whether they are seniors in the community or are residents of nursing homes. In the past, many things have been planned for seniors with no consultation with those persons who best know what seniors require. We sincerely hope this consultation process will continue as we endeavour to enforce the amendments to the Nursing Home Act.

Thank you.

MR. CHAIRMAN: Thank you, Mrs. King.

Questions or comments: Mr. Cooke.

MR. COOKE: Thank you, Mr. Chairman.

I'd like to just raise the matter of the residents council. I agree with you that it's appropriate that residents councils are mentioned in the Act and recognized in the Act, because they are important and I think they can be useful. But we're trying to look -- some of us have concerns about the balance of what role and responsibility the residents council has, and whether there is a shift taking place in the proposed amendments, from enforcement being with the Ministry, to a role of enforcement going to the residents council.

What would your opinions be if we were looking at further amendments to the bill that would try to correct that balance, and make it clear that the enforcement of the Act remains with the Minister of Health and that residents councils obviously have the obligation and the right to

raise concerns that they have, but it's not their responsibility to investigate those concerns?

MRS. KING: We would totally support that amendment, if it were made. I have reservations about putting that type of responsibility on, for the most part, eighty-four-plus in age, and most of them frail, and that is why we stress the community committee.

But in some instances, you are not going to get the people in the community to respond to that, and I totally agree, it should not be the responsibility of the residents committees to investigate. It should only be their responsibility to report. And I think the Ministry should be totally responsible.

MR. COOKE: I also have a concern that in the statement of principles, there is an allusion that the statement of principles is really a bill of rights, and an argument can be made that the proposal in the legislation, in order to enforce it, would have to be part of a contract that would be signed between the residents of a nursing home and the owner of the nursing home. And then -- I am not a lawyer -- but then the enforcement responsibility would be through civil litigation and the responsibility, of course, would be on the residents.

Would you support amendments that would convert this statement of principles to a bill of rights and would make it subject to the same enforcement provisions as the rest of the Act, particularly the fines and the enforcement responsibility being with the Minister of Health?

MRS. KING: Yes. I would have no qualms about supporting such an amendment as that. I do think that the bill of rights, if you will, of the principles could be called a bill of rights. And the Minister has said it must be posted in every nursing home.

But I still would like to emphasize the type, the condition of the residents that we are dealing with. They are elderly; they are frail, and in some instances are not even capable of accepting that type of responsibility. We believe that the Ministry should be totally responsible for the proper running of a nursing home, not the residents. The residents go into the nursing home expecting quality care. If they don't get it, it is the obligation of this government to see that they do.

MR. COOKE: I know I talked to you before about nursing homes and your concern of the need to have the community involved and aware of problems in nursing homes, but also aware of residents and their needs, and so forth.

One of the amendments that I am looking at is the

possibility of when the annual inspection report, or annual inspection, takes place for the renewal of the license, and as well, if a new license is being issued or if there is a transfer in ownership, and therefore a licensing being transferred, that under all those circumstances there should be the opportunity for public hearings on the license, and at that time as well, the past inspection records for the past year and any surprise inspection reports or any of that kind of information would be made public, as well as it would give the opportunity to residents, relatives, members of the community to make presentations to the licensing group so that the community has input as to whether that license should be renewed with the current owners.

Would you comment on that type of a proposal?

MRS. KING: Perhaps that type of proposal, with the public having the information and being able to appear for, and also to have a say.

I mentioned in my statement, we are extremely concerned about some of the people who have been granted licenses to run nursing homes. I think I have expressed publicly that the seniors do not want anymore Mr. Buxbaums running the nursing homes, that type of thing.

It came out in the news just two days ago that the province had taken over a nursing home in Richmond Hill. And when that became public, it was announced that they knew as far back as last August that the residents were at risk. Why did it take until February?

MR. COOKE: Actually, I can show you my file. The Ministry knew back in 1983.

MRS. KING: Eighty-three?

MR. COOKE: The same problems existed back in 1983 and the home has been charged three times, different years, for the same violations that eventually resulted in the home being taken over.

MRS. KING: Then my question is why the license was ever renewed? And yes, I think that public input, because I have, when I said by personal observations, I have gone into several nursing homes where we have heard of complaints and residents not being treated properly, and if we had a week I could tell you some horror stories. And that is not good enough for the seniors of this province. That just is not good enough, that quality of care.

And I put it down to the profit motive. As I said, when profit is a motive for running a home, corners will be cut to ensure that profit. And you are looking at the

people in these nursing homes who literally built this country, and they deserve a dignified quality of care. It's their right.

MR. COOKE: I agree.

MRS. KING: And they are not getting it in many instances. And I think this is a question that has been before the public and before the government for many years without very much being done about it. And we are totally concerned with this totally.

I have met with the Minister over the period of a year, off and on, trying to solve some of the things that we have found, personally found wrong with nursing homes. One of the major things that I am concerned with -- and I will repeat it -- is the type of persons that has a license to run a nursing home. And when the government finds a nursing home that is not living up and providing the quality of care to which I think seniors are entitled, then it shouldn't be a one-week period before they do something, never mind four years. They are too slow in correcting the inequities in nursing homes, and that's really our major concern in this.

Why we say that our objective in this province would be to have no privately owned run-for-profit nursing homes, is because in inspecting most of the homes for the aged, which are municipally and provincially run, we find a vast difference. The homes for the aged, for the most part, are very well run with very compassionate staff. That is not true in a lot of our nursing homes. It's of major concern with us.

MR. COOKE: Thank you very much.

MR. CHAIRMAN: Mr. Cordiano.

MR. CORDIANO: Thank for your presentation, Mrs. King. I just wanted to talk a little bit about the role, as you see it, of the residents council advisor and to get your opinion about whether that role is going to benefit residents of the nursing homes, and what implications that has for the nursing home, how we might improve the operation of that home?

MRS. KING: Well, we started one level with residents council. We go to community committee. Then we go to the advisor. And then I presume we go to the Minister. So we have four levels.

MR. CORDIANO: Well, I think the proposal here is for each of those groups to work in tandem or to work together.

MRS. KING: Mm-hm.

MR. CORDIANO: So I don't think it's a level of reporting.

MRS. KING: You don't think it's a level of bureaucracy that perhaps we don't need?

MR. CORDIANO: We were talking about the role of the advisor yesterday, and I think what was envisaged yesterday, or what the people who set up this advisor, what they saw the role of that advisor being, is that person would have responsibility for more than one home or would be an advisor to more than one home and therefore could relate experiences to the residents council.

MRS. KING: So a liaison ---

MR. CORDIANO: A liaison between homes.

MRS. KING: It would be advisable probably to have an advisor for, as you say, more than one home, and to take the complaints of the residents council and the committee, the community committee, to an advisor who then in turn could report to the Minister and maybe could handle some of the things without a great long consultation.

Our objection, as I have said before, our objection is the length of time it takes to correct what is wrong in a nursing home. It can take years. And our question on that is why?

MR. CORDIANO: That's the bottom line.

MRS. KING: Yeah. That's the bottom line. It just takes too long to correct.

The other thing is, I think most of you will remember a couple of years back when Elm Tree Nursing Home was charged with eighty-eight violations, and most of them -- over half -- thrown out of court because the wrong person was charged. Now, I do hope the Minister has made the owner and/or the administrator responsible for violations rather than having to find the actual person who committed the violation, because it might be committed at 3:00 o'clock in the morning and who's going to see it?

The owner of that home and/or the administrator, both of them, are responsible for violations that go on in that home, and should be held responsible in the courts. And I am sure this is what happened to Elm Tree, is that the wrong people were held responsible.

There was another thing that we objected to at that time, and that is the fact that in most cases, when an

inspection of a nursing home takes place, the administrator is notified of when the inspector will be there. Now, if I got a phone call that I was going to have company in fifteen minutes, I would rush around and tidy up the house. And I'm sure the administrators do the same. I do not believe that they should be notified of the times of inspections. I think they should all be surprise inspections.

And also the types of things that are inspected should be much more comprehensive than they are. It's fine to inspect the fire extinguishers to make sure they're filled, but the quality of food, even the quantity of food, and above all, the temperature of the food as it's served are very important to residents.

I am sure most of you, if you were being served a hot meal, would not want it served cold. And one day in Elm Tree when I was in there, there were twelve residents who went down to the dining area and were told that the food had run out. That is not acceptable.

And every one of these things should be corrected. If we are going to have privately owned, run-for-profit nursing homes, then let's have regulations that force those people to give quality care to the residents.

Privacy was another concern of ours. We would like to see future nursing homes, if they were going to be built, the criteria should be two bedrooms, not four bedrooms. That allows a little privacy, a little dignity to a resident. I think that in many homes in Ontario, that we should all, even as citizens, be ashamed that we've allowed it to happen.

MR. CORDIANO: With respect to the advisory -- the residents council, rather, there must be -- let's see; subsection, Section 17E refers to the number of people to be elected on the residents council, and in fact there must be a minimum of three.

MRS. KING: That's for a request.

MR. CORDIANO: And you point out a concern with the fact that perhaps there may not be three people who are coming forward to form a residents council. What advice do you offer if that's not possible for three people at a nursing home to form a residents council? What alternative is there?

MRS. KING: My question, of course, was what happens to the home where three people do not come forward and request a residents council? And that is why I think it's vital to have a council formed of interested parties in the community. They don't even have to be family and friends.

There are many residents in nursing homes who do not have family and friends. They are dumped.

I think that if you could get three interested people in the community where the nursing home is located to form a council for the residents, that that might correct the situation in a home where a residents council was not requested.

I don't think either it should stop there because the residents, just by necessity of age and demographics, change day do day. So perhaps a home that did not request a residents council this month might have three people that would request one next month. And that should be followed, in order to -- if a home does not have a residents council, let's keep after them and see if we can't get one, in other words. And I think that would be the duty of the local residents who are interested in the quality of care that people were receiving.

MR. ANDREWES: But you can't impose that?

MRS. KING: I don't like the word, "impose". I don't like anything being imposed on anyone. And are you going to have a good council of, we'll say, not less than three people if it is imposed upon them?

MR. ANDREWES: You used the term, "keep after" them.

MRS. KING: I am saying the change in the residents themselves, which just by age alone, some come in, that in the future if you don't have a request for a residents council this month or this six months, perhaps six months down the road there would be three people that would request one. And I think it should be followed up in a home where there has been no request, that the community committee should follow that up to try and set up a residents council in those homes that don't have one.

MR. CORDIANO: But it's possible to have -- obviously, it's possible to have an advisory committee and not have a residents council.

MRS. KING: Mm-hm.

MR. CORDIANO: And as a result of that, am I correct in assuming that -- I am asking the Ministry staff -- because that's the way I understood it?

MR. CHAIRMAN: Is it possible to have an advisory council without having a residents council?

MRS. KING: I think it should be possible if it isn't.

MR. SAPSFORD: No. The intention was that the committee would function with the residents council rather than being created independently.

MR. CHAIRMAN: An advisory capacity to the residents council.

MR. CORDIANO: To the residents council.

MRS. KING: But are you saying that if there was no residents council, there would be no community committee?

MR. SAPSFORD: That's the way it's currently written.

MRS. KING: I object to that. I object to it on two fronts. I object to it because I think that deprives the residents of that home of advice, and I object to it because I think it's absolutely vital that we have community councils of interested parties.

MR. ANDREWES: Let me just clear -- sorry, Mr. Cordiano -- but the legislation doesn't provide for a community committee at this point in time at all.

MR. COOKE: No.

MR. ANDREWES: That concept is something that you

MRS. KING: I thought the suggestion was made that there be a community....

MR. ANDREWES: Not in these amendments.

MRS. KING: Not in the Act? Not in these amendments? Well then, I would like that to be put into the Act. I do think the community council is going to be even more important than the residents council, simply because of the age and the frailty of the residents. I would not like to see a lot of responsibility put upon people.

MR. CORDIANO: I don't follow this. Perhaps we can get clarification from the Ministry staff. But I understand that Section 17 E, subsection B, that there is more than three members who live in the area in which the nursing home is located to be appointed by the Minister.

MR. CHAIRMAN: Subsection 1 is the key: there shall be established for each residents council a residents council advisory committee composed of.....

So it's dependant upon having a residents council.

MR. CORDIANO: Oh, I am not disputing that. I am just saying that there is, in fact, membership from members of the community on that advisory council.

MR. COOKE: There isn't a residents council advisory committee if you haven't got a residents council.

MR. CORDIANO: I am not arguing that. I am just saying that if you do -- and it's also a question of which one do you establish first? Obviously, you are going to have to establish the residents council first, and then from that, you are going to develop an advisory group, having from it the members of the community.

But is it not possible to have an advisory group that takes an interest in what the home is doing and come forward and say, "Hey, we'd like to form a committee. We'd like to have some carriage of responsibility for that home with respect to that advisory role," and perhaps establish that residents council, if that's not been established, going the other way around?

MR. COOKE: (Moves head from side to side)

MR. CHAIRMAN: That strikes me as requiring an amendment. But you can ask Mr. Johnson.

MR. JOHNSON: I suppose in a sense any committee of any kind can be formed. But in terms of the legislation, it contemplates, as you have already indicated, that you start with the residents council; out of that, you appoint some members plus some people from the community to the advisory committee. That's all the ---

MR. CORDIANO: But let's take the example of a small town where interaction among community members is far greater than you would have in a larger urban setting. And obviously, there are family members in this home. And I would think that, if there is a greater participation, it would be in a smaller town.

And that sort of thing may happen -- I am not saying -- the likelihood of that happening is very small indeed, given the way the legislation is written, but what I am saying is that there is probably greater interest in that situation occurring in a smaller town.

MR. JOHNSON: Uh-hm

MR. CHAIRMAN: At the moment, it would require an amendment to have anything but a very unofficial group of people who may or may not be accepted as advisors to the administrator and residents. That's all I am saying. At the moment, established first is the residents council, and

then from that established part, representation of the residents' council plus this advisory group. Then it goes on to require a change to get that kind of....

MRS. KING: I hope the change would be made because -- I will go back to fear of reprisal. It is fine to put it down in words and in an Act to say that no resident will -- there will be no reprisal against a resident what makes a complaint. Convince eighty-four, eighty-five-year-old seniors who have nowhere else to go that they have no fear of reprisal. It doesn't happen that easily. They are still frightened.

In some cases, the members of their family are frightened in that. And as I say, it's fine to say, but put it in the Act and it should be there, but to enforce it is something else. So an outside community committee to advise the residents council and to hear the complaints of residents to me is vital, disinterested parties, if you will.

MR. CHAIRMAN: Mr. Cordiano?

MR. CORDIANO: Well, certainly I think that that would, as I said earlier -- I just want to reiterate that point -- that agreed in a smaller town, it's probably ---

MRS. KING: I live in one.

MR. CORDIANO: Exactly, with a population 2,000 or so, and you may have a nursing home. I don't know if that situation exists. But in smaller towns I would think the people have a greater interaction with the nursing home and other institutions in that town.

MRS. KING: You are right about the interaction, but that does not preclude that in a city such as Metro Toronto there wouldn't be family members and friends very concerned about a resident in a nursing home which they felt was not being run properly. It can happen right here in Metro Toronto as well.

And I think wherever a nursing home is located, that from that community itself, be it in the centre of Metro Toronto or be it in Tottenham where I live, that there should be advisors to that residents council from the community itself, not from government, but from the community.

MR. REYCRAFT: Mr. Chairman, have we been told by other delegations how many of the 330 nursing homes already have residents councils?

MR. CHAIRMAN: Not as yet.

MR. REYCRAFT: The information, as I recall that was presented yesterday, was that there was a statement made that most of them do so. But do the Ministry officials know what percentage of the homes do have residents councils now?

MR. SAPSFORD: I don't have that figure. I can find that out quickly. It is most of them.

MRS. KING: May I ask how effective they are?

MR. SAPSFORD: I can't answer that.

MR. REYCRAFT: My point in asking the question, Mr. Chairman, really was that we are worried about not being able to get an advisory council because we don't have a residents council may not be a very serious concern if, in fact, we have residents councils already in most nursing homes.

MR. CHAIRMAN: We'll get that information for you as soon as we can.

MRS. KING: I would love to know how effective the existing residents councils are in the nursing homes.

MR. CHAIRMAN: We'll ask the organization when they come before us.

MR. CORDIANO: Hopefully, we could make them more effective.

MR. CHAIRMAN: Are there any further questions? Mr. Andrewes?

MR. ANDREWES: Perhaps I could ask Mr. Johnson's opinion here, because Mrs. King has made a rather novel suggestion. Seventeen (d) says that whenever at least three persons who are either residents in a nursing home or representatives of residents so request, a residents council shall be established.

I would assume that -- I don't know how you describe legally "representatives of residents" when, in fact, you go down to 17 D (3); when you talk about the residents council advisory committee, they must be the legal representative. So, in fact, if three people in the community convinced the residents that they could be their representatives, I would assume then they could form the residents council. It doesn't say "legal representative".

MR. JOHNSON: That's correct. It would be sufficient if three such people came forward to then get a residents council established. They wouldn't be the sole ---

MR. COOKE: They would have to have some basis. Wouldn't they have to have some claim to be some representatives of residents?

MR. JOHNSON: Yes.

MR. COOKE: I think this whole section was put together very quickly.

MR. JOHNSON: And, of course, I think it follows from that that we didn't think that only the three that came forward would be the council, that at that point the step should be taken to establish a council that would include all residents, or in the case of those that aren't sufficiently competent, their family representative, or whatever.

MR. CORDIANO: So in fact you could have representatives from the community on the residents council? That's what I was getting at earlier.

MR. JOHNSON: Yes.

MR. CHAIRMAN: They could be the residents council.

MR. CORDIANO: They could be the residents council, yes.

MRS. KING: But they are not the residents; they should be an advisory committee to the residents.

MR. CORDIANO: But our concern about not being able to set up or establish a residents council, the very fact that if you have frail and elderly people age eighty-five who couldn't establish this residents council, you have people from the community that act as their representatives to be on this residents council.

So that's already in the legislation.

MRS. KING: Yeah.

MR. CHAIRMAN: Mr. Andrewes.

MR. ANDREWES: Mrs. King, you have made the statement on the second page of your presentation that the ideal situation would be no run-for-profit nursing homes. And I think you went on to say that in your surveys that the homes for the aged in your view had a more compassionate...and were better run and where the staff were more compassionate and delivered a better level of service.

MRS. KING: That's true.

MR. ANDREWES: We had before us yesterday a group who said that there was no substantiation to that statement. I think in terms of this committee and the workings of another committee, the Select Committee on Health and Social Services, it would be very helpful for us if you could give us your substantiation for making that statement.

MRS. KING: My substantiation for making it is just through personal observations. In a village four miles away from where I live we had a home for the aged in Beaton. The people are happy. The residents are happy. It is beautifully clean. There is nursing, nurses on call, a doctor on call. And they provide recreation, they provide crafts. It is a beautifully run home. And I have been in three or four others like that. I haven't been in them all, so I don't know if there are bad ones, but I would hope not.

But from the observations that I have made in the nursing homes that I have visited, as compared to the homes for the aged that I have visited, the homes for that aged come out on top. And I would specify Beaton in particular because I visit people in there. They love to see people, so you drop in for ten or fifteen minutes. It's a community service to them and they love it. And that's my most frequent place of visiting. And it's just an absolutely beautiful home. And the residents are smiling and happy. And you can walk into some nursing homes and never see a smile all the hours you have been in there.

One of the things about nursing homes that we have objected to is that in some homes some of the qualified people who happen to have been on the union, have been fired, and very unqualified people have been put in their place. And this did happen at Elm Tree. I went in there on a Sunday afternoon in June, beautiful day, and what struck me first was that the office of the administrator was beautiful, fresh flowers all around. It was a lovely place. I had the name of a gentleman who I was ostensibly visiting. You opened the door from the administrator's office into that home, and in the first place, the odour would put you off. It was drywall that was very, very wet at the bottom, and there is a terrible odour from that.

I saw one instance of a gentleman who had no legs at all in a wheelchair. He had been sitting leaning forward. I assume he was watching television. And all of a sudden the attendant came up and said, "I am taking you to your room." She pushed that wheelchair -- well, if it had been on a highway, she probably would have been arrested for breaking the speed law. And he just barely got back into the chair. His elbow missed the door jamb by that much. He was trying to shift himself back in the chair so he wouldn't fall out. That is not proper treatment for a

disabled person, and he was a senior besides.

There were many things that I observed there, and I know that the home was made to improve. I have not been back since improvements were made, if indeed they have. But with me going in there several times and then comparing it with the home for the aged in Beaton, it's like two different worlds. And I will stress Beaton and Elm Tree because I am most familiar with those.

MR. CHAIRMAN: We are limited to one further question because we are running so far behind.

MR. ANDREWES: One more. I just want to come back to your statement, because the statement that you make in here then is based on personal opinions.....

MRS. KING: Yes.

MR. ANDREWES: ...rather than on any survey conducted by the United Senior Citizens?

MRS. KING: We did not do a survey of nursing homes, no.

MR. ANDREWES: Okay.

Just briefly, on page two, you say: We know that many residents in nursing homes are being over medicated. Again, yesterday the O.N.H.A. indicated that they only administer medication that has been prescribed by a doctor. Can you comment on that?

MRS. KING: May I tell you why I made that statement? It's because we have received literally hundreds of letters and telephone calls from family, friends and residents, who have said that they were sedated when they went into a nursing home and kept sedated, and we believe what these people are telling us. It's not from a survey, no. It is from personal letters and phone calls.

MR. ANDREWES: I guess what my concern is, have you evidence that nursing home staff are violating the orders given by doctors in prescribing medication that was ---

MRS. KING: I have no hard evidence of that. I only have the statements of our seniors and their family and friends, that the residents have been sedated to the point where they are almost zombies and they are kept sedated until such time as they can be kept quiet. We also know or have been informed of cases where they have used restraints, such as straps and....

MR. ANDREWES: Contrary to the medical instruction given?

MRS. KING: I don't know that.

MR. ANDREWES: Thank you.

MR. CHAIRMAN: Thank you, Mr. Andrewes.

Mr. Mansfield, do you want to add anything?

MR. MANSFIELD: No.

MR. CHAIRMAN: You have been very quiet. She's your spokesperson?

MRS. KING: When he gets a woman beside him, he doesn't get a chance to talk. You know that.

MR. CHAIRMAN: I've never noticed that that's been an inhibitor for some of the men here on the committee, including myself.

Thank you very much for attending today.

MRS. KING: Thank you for hearing us.

MR. CHAIRMAN: Thank you. We appreciate your participation.

Canadian Pensioners Concerned is our next deputation.

Ms Woodworth? Welcome. You have been before the Social Development Committee before. Nice to see you again.

MS WOODWORTH: Thank you.

MR. CHAIRMAN: So you know how we operate. The Members have your statement already. It's been circulated to them. So you can present it anyway you'd like and then we'll go to questions following that.

MS WOODWORTH: Thank you.

Mr. Chairman, thank you for the opportunity of coming before you today. Our statement is rather brief because we believe that this committee must be pretty fully aware of the conditions of nursing homes in this province. So we have chiefly given our attention to a few suggestions.

At the present time, many nursing homes are prisons of loneliness and despair. Barely adequate and often very inadequate care, fearfulness and helplessness are shocking conditions of life for the vulnerable elderly.

Every senior in the province -- and I mean every senior in the province -- dreads the day when he or she may have no alternative but such care. We in Pensioners Concerned applaud your expressions of concern as expressed in the proposals of the Nursing Home Amendment Act, proposals ensuring strong public control and supervision to the ends that nursing home residents have not only the best possible care, but also the best quality of life. We wish to put before you the following comments with some proposals.

Residents' rights:

It is assuring to the elderly and their families that residents' rights are clearly defined, to be posted in each nursing home, and that contracts on admission will guarantee the operation of the home to be in accordance with these rights. We are particularly concerned that this assurance must be made a fact by strong enforcement of other provisions in the Act which regulate licensing, strengthen inspection procedures, define procedures to report neglect and maltreatment, require submission and posting of annual financial statements, and levying of substantial fines in cases of contravention of the Act.

Staffing:

The quality of care and life of a home depends on the skill and ability of staff, staff trained to work with the elderly and their families. Nutritious food, a pleasant environment, nursing care, recreation, financial ability are basic requirements but do, by themselves, do not make a home of a nursing home. Quality of life and a home result from the teamwork of a staff accountable for good care, trained to provide it and adequately paid for their services.

We wish to recommend that regular, at least annual, staff training days be provided and required for all nursing home staff. We recommend that this training be based on understanding and ministering to the needs of the elderly: health, physical, emotional and social.

Further, we would like to recommend that the emotional and social needs of residents, as Mr. Elston noted in his speech before the Legislature, that emotional and social needs be acknowledged by the appointment of consultants and staff trained to provide service to meet these needs, the training of choice to be professional social work.

We recommend that staff at the provincial level be expanded and strengthened to enforce the proposed legislation and to support and encourage and motivate nursing home owners to upgrade and enhance services.

We would also suggest and recommend that residents council advisors as proposed in the Act should have responsibility to assist in this supportive function of encouragement and support for improvement of services.

Possibly that same residents advisor -- no. I think I take the word "possibly" out -- that resident advisor, it seems to us, should be a person not only with some training in relation to health needs, but also training in relation to emotional needs.

Regarding the residents council advisory committees, in our opinion, nursing homes must be opened up to their communities to assure that their services are in fact providing quality care, are not in any way degrading or abusing residents, and also to bring the elderly into contact with the life and vitality of their multi-generational communities. The proposed advisory committee, if properly constituted, could be helpful in this opening up. Careful non-partisan appointment of the three members from the community is basic.

We recommend that community appointments be selected from the following categories of citizens: seniors organizations, health care organizations, women's organizations. In our opinion, such a selection should bring forward concerned, able persons. We selected those three groups because it seems to us that no matter how small the village where the nursing home is or how large the city, you are going to find seniors, health and women's organizations present.

A further suggestion re opening nursing homes to their communities is the development of a volunteer program in each nursing home. Such a program would complement and supplement staff, particularly in the provision of recreational programs and friendly visiting with the residents. Volunteer programs are now generally accepted in hospitals. So there is some precedent for such a development in nursing homes.

Guidelines and some assistance would need to be available from the province. Promotion and development could be a responsibility of the residents council advisory committees.

Granting of license for new homes:

The amendment notes that the granting of licenses should take into account the possible effect on the concentration of ownership of nursing homes, and also in the balance between nonprofit and profit oriented nursing homes.

Ontario Pensioners Concerned recognizes the need for nursing homes at the present time, requires both the profit and nonprofit homes. We wish to emphasize, however, that we are concerned that no profit should be made at the expense of quality care, adequate staff, and decently paid staff.

For this and other reasons we strongly recommend that a balance toward nonprofit homes be strengthened. This is a balance through the granting of licenses. We recommend that a system of grants be put in place to encourage community groups, such as churches and ethnic groups, to establish and operate nursing homes. In our opinion, this would encourage the development of Canadian enterprise, the development of homes of modest size, and closely related to their communities, giving high calibre caring services.

Ontario Pensioners Concerned is encouraged by the thrust of the Nursing Homes Amendment Act. The principle fundamental to the Act, that a nursing home is first and foremost the home of the residents, brings hope to many despairing senior citizens and their families.

MR. CHAIRMAN: Thank you very much, Miss Woodworth. Questions or comments from Members? Mr. Cooke.

MR. COOKE: Just a couple of questions:

I would just like to ask you on the residents councils and the residents council advisory committee, in looking at some of the powers that are granted to this body under the amendments, such as receive and investigate complaints from residents and other persons; do you think that that's an appropriate role for the residents council or the residents council advisory committee to investigate complaints, or do you think that that would be more appropriately carried out by the Ministry of Health?

MS WOODWORTH: Mr. Cooke, I think this whole area of advisory committees is a pretty dicey one, but on the other hand, it is one way of getting at some of the basic problems. Many seniors I have known in nursing homes in their eighty's, in their ninety's, one of the things they feel most disadvantaged about and most helpless about is that they have no control over their lives. They can't say -- there is no way they can speak up about anything.

And some of the little things they want to do, they're exceedingly little. I mean, it's ridiculous. So therefore I think, although it has its hazards, I would like to see residents have the right to make complaints to this committee.

MR. COOKE: I am not suggesting they shouldn't have the right. We have had a discussion before, and actually

your comments that you made to me before have had an impact in that originally my reaction to this section was that the whole blasted thing should be scrapped. But I agree that residents councils have a role and that they should be recognized in the legislation. The balance that has to be struck is that we don't shift the responsibility of enforcement of the legislation to residents or resident council advisory committees, because my own feeling is that it would be extremely difficult, it would be ineffective. And the bottom line could be that when you have residents council advisors coming in, that it would be reasonably easy in some cases for them to be co-opted into the system and be less than objective and therefore the enforcement of the Act could be weak.

MS WOODWORTH: Right.

MR. COOKE: So I am looking at this remaining in the legislation, but that we have got to very carefully look at the role and the responsibility. If a resident has a complaint that is a potential violation of the Nursing Home Act, I agree that resident has a basic right that that resident should be able to complain. But would it be more appropriate for the resident to complain to the advisory committee or more appropriate for the resident or the residents representative to complain to the Ministry of Health for an investigation, the inspection services?

MS WOODWORTH: I agree that the province certainly has to have the responsibility. Complaints maybe could be...the rule could be that they would have to go to both, but that there was understanding that in the long run the province is responsible for the proper operation of those homes.

MR. COOKE: Maybe the appropriate wording would be, instead of "receive and investigate complaints", that it should be "receive and report complaints".

MS WOODWORTH: Yes. Right. That's the word, yes.

MR. COOKE: Rather than having any responsibility for investigating.

MS WOODWORTH: I wonder also about, there was no definition, that I remember, of the role of an advisor in the home....

MR. COOKE: Right.

MS WOODWORTH: ...and the relationship of that advisor to the provincial supervisory process, whatever it is. And it seems to me that that needs very careful definition, and that advisor is going to have to be a very able, astute person.

MR. COOKE: I agree. This whole area I think potentially could be helpful, but it also, if we don't do it right, it could be very damaging. That was basically what I wanted to talk to you about.

Well, I will ask you one other question: One amendment that I would like the committee to consider -- and I haven't drafted it yet -- but an amendment that I would like to look at -- because again, I buy your argument that the community has to become involved and has to have an understanding of nursing homes -- is: When the annual inspection takes place and the annual renewal of the license or the granting of a new license, a brand new license, or the transfer of a license to a new owner takes place, that rather than that being done by the Ministry of Health without the involvement of the staff, the residents, the relatives of the residents, and the community, that we look at some kind of a procedure not unlike that of the public hearings that are held when a liquor license is being issued, where the community has the opportunity to participate at the hearing, and at the same time the inspections for that year would be made public and would be available to people so that the record over that one year would be clearly made available to the community, and there would be that accountability built right into the system. And then if there had been a horrible year, the Minister of Health would have to respond as to why they are renewing a license of a home, as they did on several occasions to Country Place, of why that license was ever renewed before, and all of this would be publicly aired.

Would you see that as a positive amendment worth considering?

MS WOODWORTH: That sounds very good to me, because it places the responsibility with the department, but it gives the community residents, their families, an opportunity for input. Sounds very good.

MR. COOKE: Good. Thanks very much.

MR. CHAIRMAN: Mr. Cordiano.

MR. CORDIANO: Thank you for your presentation.

I just wanted to ask a few brief questions and to start off by a question of the residents council where my colleague left off, and with regard to the advisory committee and the role of that committee, what in your opinion, you said that perhaps the committee -- it's important to have community input. It's important to have members of the community represented. I think that's what the initiative here aims at: to get the community more involved.

The other thing is that the Minister is to appoint these people. And in your opinion, if the Minister appoints these people, would it not be as a result of the Minister wanting to ensure that there were people on this advisory committee that would in fact serve the interests of the residents and not the nursing home? Because I suspect that a little bit of antagonism there with respect to the nursing home operator, and obviously the residents and the kinds of things that are being said have happened over the past, and we have documented proof of some of those events occurring.

I would think that if the responsibility falls on the Minister in the final analysis, then the Minister's responsibility is to appoint people who are certainly going to have a vested interest and certainly are going to have a responsibility to look into the proper operation of the nursing home.

Do you have confidence in the Minister appointing people to the advisory committee that certainly will reflect that point of view, or is it that there is a lack of confidence there that these people will have, for example, the interests of the residents at heart?

MS WOODSWORTH: Mr. Cordiano, just for clarification: You used the word "antagonism"; you thought we were being antagonistic?

MR. CORDIANO: No, no. No, no. I meant that, obviously, you know, when you live in a home and there are a number of problems, and if I were a resident, I certainly would be... "fearful" is one of the adjectives that were used, and certainly I would be less willing to cooperate and, as a result of that, there is this feeling of distance between the operators and the residents. That's what I was trying to point out.

MS WOODWORTH: Right.

MR. CORDIANO: So what I am suggesting here is that the effort here is to appoint members from the community that have the interests of the residents at heart, and it's their interests that they are going to advocate for, first and foremost. And now I am asking you if you think that there would be a breakdown in that mechanism as a result of the Minister appointing people from the community?

MS WOODWORTH: I think there is a possibility of all kinds of breakdowns in these amendments. But also, I think they have to be tried. And one of the breakdowns that we discussed in preparation of this material was the respect the community's got to have for the people that are appointed to these committees, and if they are political

appointments, they are going to be pretty meaningless, I think, from the point of view of community respect.

MR. CORDIANO: Sure.

MS WOODWORTH: And this is why we selected these three possible groupings from which appointees should come. I respect the work of those people who are running nursing homes. It's a hard job; there is no doubt about that. And I would hate to see people go on those committees who were out to prove that that operator was doing everything the wrong way. I think they've got to be people of some integrity and a fair amount of intelligence who go in to ensure that in fact the law of this country is kept and that seniors are given proper care.

MR. CORDIANO: I think what I was trying to get at, and I probably used the wrong word, "antagonism". I meant to say that there is an adversarial sort of situation that emerges in homes where there are some very serious problems. And I would think that the role of the advisory committee, and the role of members of that home who are on that advisory committee, obviously they are going to try and improve the situation. And I think that what we might foster from this is a cooperative spirit, not just of the residents themselves, but hopefully with the operator of the home, and some good may come out of that. Perhaps I am a little idealistic in thinking that, but I think that you have to start somewhere, as you pointed out, and that process will lead to betterment.

MS WOODWORTH: It would seem to me that once the situation reaches the point where there is a situation which is well-known as being not in the interests of the residents of that home, and where there has been reports have come through from inspectors, then I think that's a provincial responsibility, and the advisory committee can maybe do something, but it can't do a lot.

MR. CORDIANO: Right.

MS WOODWORTH: We used the words "encouraging" and "upgrading" and "enhancing" services. And I would see that in that respect advisory committees could be extremely helpful, not that they would flinch from pointing out infringements under the Act, but they've got to do more than that.

MR. CORDIANO: I agree. And I think that's what the role of those committees should be.

I just wanted to go onto another point. Perhaps I will defer at this point and allow someone else.

MR. CHAIRMAN: Try to restrict yourself to another five or so minutes. Mr. Baetz is on the list.

MR. BAETZ: I just wanted to say too that I appreciated your presentation. I haven't heard from you for a long time, haven't had the privilege, but nice to see you again.

I was interested in your comments on the profit and nonprofit nursing home operations. You didn't take the same, quite the same hard line that the United Senior Citizens of Ontario took just prior to your presentation. But you were, I think you come down on the side of preferring the nonprofit operators.

I am wondering whether -- and I'm sure you have over the last decade seen many nursing homes in this province -- I am assuming that; maybe it's wrong -- but has it been your impression that invariably, invariably where there is the lack of quality care that you have been talking about and are concerned about, that invariably you will find that in a profit, in a home for profit, or are you liable to run into that situation whether it's a for-profit or not-for-profit operation? That would be my first question.

In other words, is it -- you know, I sense from the presentation that was made prior to yours that mention seemed to be where it's for profit, that's where you're likely to find more concern about how much money you can make and forget about the quality of care. What is your experience in that?

MS. WOODWORTH: I regret that I didn't hear all of Mrs. King's presentation. I think we agree generally probably, although our presentations are somewhat different. I don't think I can say invariably. The thing that I can say without any question is that I don't see where profit can be made in the care of the elderly. I believe that the majority of the expenses go towards staffing. The other expenses are food, heat, and accommodation.

Now, if you cut into any of those to make any great amount of profit, you are cutting into quality care. I believe that in fact in some provinces the ruling is that there are no profits, no profit nursing homes, just for that very reason. So since that is my opinion, and the opinion of Pensioners Concerned, we do not say that there is not a single for-profit home in this province which is not giving bad care. I don't know that, and I assume it's probably not true. But we do say that we don't see how a profit can be made and quality care given...very difficult.

MR. BAETZ: I suppose the operators would say that if the per diem allowances are high enough, they can provide both very easily. You can provide high quality

care and still allow for some reasonable level of profit for the operator.

MS. WOODWORTH: But that means that we, the taxpayers, are making a profit for the profit organizations, doesn't it -- I mean, if we increase per diems to that amount? And as pensioners, I don't think we could accept that point of view.

MR. BAETZ: No.

Do you -- getting a little philosophical here, but I guess eventually that's where social programs go back to, I mean the whole question of choice, to provide the senior with choice of going to either a home that is operated for a profit or one that is a non-profit; I mean, does this mean anything to you, that this is an important part of our life, of our society, that we provide the greatest possible degree of choice and don't simply say, "Look, all of the homes here are going to be operated by government," presumably, or by non-profit organizations?

MS WOODWORTH: I think that's a very philosophical question and not quite where the real world is these days, because people get nursing homes that they can afford, that are near their families. They make the best arrangements they can.

MR. BAETZ: So maybe what you need is a variety of types of nursing homes then, in other words, to provide that kind of real choice for the individual family who has to have a member become a resident in a nursing home.

MS WOODWORTH: Yes, we agree with the variety. As I indicated, we suggested that there might be a variety of community groups, in fact, who would be glad to pick up on the possibility of providing nursing home care if it was made possible for them to do. I don't see it really as giving citizens a choice, though, if we have to subsidize the profit nursing homes.

MR. ANDREWES: What do you mean by community groups that would if "given an opportunity" to pick up on; what do you mean by "given an opportunity"?

MS WOODWORTH: We were speaking particularly of ethnic groups and church groups, some of whom seem to us to be doing a fairly good job.

MR. ANDREWES: Yes.

MS WOODWORTH: I don't know what your system of granting is, or is it a system of per diems only?

MR. ANDREWES: You are talking about grants then to

help them start, capital grant?

MS WOODWORTH: Yes.

MR. ANDREWES: Is that not a subsidy?

MS WOODWORTH: Yes, it is.

MR. BAETZ: Mr. Chairman, I don't want to prolong this, but the whole issue of personal choice I think is a very, very important one. It's certainly something that distinguishes us from the totally planned socialist state of the Eastern Europeans where there is no choice. There may be a good level of service, but there is no choice. There is only one system.

But in our school system, we have been saying, look... we are sort of thinking of opening up the possibilities for private schools -- and I don't know whether they are for profit or not; I suppose some are for profit -- but anyway, as I say, the....

MR. CHAIRMAN: It seems like another subject for the Select Committee.

MR. BAETZ: I think it is, yes. All right. Thank you very much.

MR. ANDREWES: Another subject.

MR. CHAIRMAN: Perhaps you will be back to talk to us.

MS WOODWORTH: Could I just say one more word on this?

One woman I know, whose name you would all know if I could give it to you, is a woman now in her late 70s, an outstanding woman who understands what we are talking about today, but also who's got to that point in her life, can she live alone any longer.

And she did -- this is speaking to Mr. Baetz' point of choice -- she lives in the City of Toronto. She did an exhaustive research job on her own behalf looking for a nursing home. She couldn't face any of it. She is living in her own apartment with as much support staff as she can achieve through her friends. So there is not much choice today.

MR. BAETZ: So maybe the answer is -- well, part of this legislation, but just more money for nursing homes, both for private and for public.

MR. CHAIRMAN: Maybe.

MR. BAETZ: Maybe. Yes.

MR. CHAIRMAN: Thank you very much, Mrs. Woodworth. It's good to see you again. And as usual, you carried the thrust and were helpful to us in terms of advice. We appreciate your time.

MS WOODWORTH: Thank you.

MR. CHAIRMAN: The final deputation this morning is from the Christian Labour Association. We have Mr. Beekhuis and Mr. Kuntz? Did I pronounce it incorrectly?

MR. KUNTZ: That's all right.

MR. CHAIRMAN: This has already been distributed to the members just a few minutes ago. I think you probably have heard already from other people who have been here, for the last deputation, at least. You can make your deputation in any way you'd like. Then we'll open it up to questions following that. Could you tell me which is which?

MR. BEEKHUIS: Okay. My name is Mr. Beekhuis. I'm a representative of the Christian Labour Association of Canada, and one of my jobs is to work with the employees of the nursing homes that we are talking about. The brief that I'll be following is the white one in your folder, and I'll try to follow that as closely as I can, and if I think something needs emphasis, I'll raise it.

Mr. Chairman, Members of the committee, we appreciate this opportunity to make this submission regarding Bill 176, and at the outset, we must state, however, that our appreciation is somewhat tempered by the fact that only last Friday at 3:00 p.m. that we learned through the Globe and Mail that this hearing was taking place.

You will no doubt agree that this left us precious little time to prepare this submission, and in essence we deplore the fact that an organization such as ours that represents some 2,500 employees in nursing homes and rest homes throughout Ontario, and which has been formally invited by the Ministry of Health to be part of the ongoing consultations, had to learn of this meeting via the Globe and Mail. However, having said that, I would like to go a little bit into the background.

In 1985, our membership were under increasing pressure from our membership to try to do something about a growing crisis in the nursing home field. Obviously, I think that's the reason that this committee is here. Most of you should have had, at one point or another, a copy of the report that we came out with entitled Serving our

Seniors. I'm sorry I do not have a copy for you today. I had intended to. But all M.P.P.'s were given one at the time that the report was issued.

That report got us into the consultations group which attempted to come up with these amendments. That resulted in the consultations thing that you do have in your folder. I understand that we were the only labour union in the province who came up with a brief in that regard. So that brings us now to this committee.

As a trade union representing employees in some forty-seven health care institutions in the province, it's natural that we first address ourselves to the various issues that directly affect our membership. Consequently, our brief will not follow the order of the bill.

We are deeply concerned about the requirements in the Bill stipulated under Section 17 A subsections 1 and 2. For completeness sake, I have stated, and we have underlined in the brief in front of you, the words that concern us. We have underlined some of the key words in this section. It is obvious that this section imposes the duty of any staff member to report any wrongdoing or perceived wrongdoing on the part of another staff member, or for that matter, anyone else, to the director. In fact, our failure to do so carries severe penalties.

On the other hand, subsection 2 makes it plain that although such a reporting person is protected from reprisal by management, this protection only applies if the reporting has been done on reasonable grounds. And in that regard, I would say also it's only valid in the situation where an employee has union representation and access to a grievance procedure.

We are betraying no secrets by stating that the word "reasonable" is a well-known legal weasle word. What is "reasonable" to one is entirely "unreasonable" to someone else. The word "reasonable" is a lawyer's delight, and we can well visualize staff members who in good faith report a wrongdoing or perceived wrongdoing to the director finding themselves embroiled in endless legal proceedings on the question of whether or not their reporting was done on reasonable grounds.

What is happening in Sections 17(a) (1) and (2) is that staff members of nursing homes are placed between a rock and a hard place. On the one hand, you are required to report on the pain of stiff penalties, and whereas on the other hand, they jeopardize their very job if they fulfill their duty by reporting, only to find out later that an opposing lawyer manages to convince a court or a tribunal that their reporting was done without reasonable grounds. Staff members are thus faced with a serious

dilemma. And I guess our basic concern here is our fear that there will be a lot of unnecessary litigation, particularly against our membership.

We are not trying to convince you of the wrongness of this section on merely hypothetical grounds. We could cite you a number of cases in which nursing home employees had to defend their reputation and their jobs in lengthy legal proceedings against entirely spurious charges of misconduct.

We strongly suggest that the bill be amended in such a way that the mandatory aspect of reporting by staff of any supposedly improper treatment be dropped. This would remove the climate of suspicion that will otherwise begin to poison the atmosphere in nursing homes. Instead, we suggest that the onus of reporting, to the director of any known abuse of residents, remains on the administrator of the home, and that any failure to do so carries with it the necessary penalty.

Our second objection to the proposed amendment concerns the absence of any submissions for adequate staffing in nursing homes. In our submission to the Ministry of Health, we graphically describe the rat-race in which the staff of virtually all nursing homes is engaged. Thus far no one has ever denied, or even questioned, what nursing homes suffer from serious under-staffing. In our opinion this can largely, though not entirely, be traced to the inadequate subsidizing of private nursing homes. The current subsidy is about twenty-nine dollars per bed per day, and if one considers that our government spends an approximate \$120 a day to accommodate prisoners, it becomes clear that the funds available for our disabled senior citizens is grossly inadequate. It is very laudable to stress that each resident shall be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. But this remains empty phraseology when it is crystal clear that there is not sufficient staff available to achieve such lofty goals.

We deeply deplore that the Bill is silent on the provision of adequate funding to make quality care possible. Furthermore, we found nothing in the proposed legislation that removed the growing disparity between funding of a municipal owned home vis-a-vis a privately owned nursing home. As you are undoubtedly aware, the former category falls under the auspices of the Ministry of Community and Social Services, whereas the latter is the responsibility of the Ministry of Health. Somehow I think that issue has to be addressed. We have in the past suggested that both ministries be merged into one, but it is unreasonable to expect -- and our staff feels the brunt of that, I suppose -- that for forty per cent less money, that people in the private nursing home sector are asked to

provide the same care.

We wholeheartedly agree that the purpose of nursing homes is to provide true homes for our disabled and infirm senior citizens, and their rights and wellbeing should be adequately protected. We are disappointed, however, that while residents receive a bill of rights, the proposed amendments say nothing about the rights of staff members. We represent the large number of nursing home staff members who must at times put up with physical or verbal abuse from cantankerous and mentally unstable residents. The extent of such abuse should not be under-estimated.

Why is it that residents are surrounded with numerous protections whereas the rights of staff members are not even mentioned? We don't suggest, of course, for a moment that physical or other abuse of residents can ever be tolerated, but in situations where sizable numbers of residents suffer from mental disorientation, staff members are often called upon to intervene and take measures to protect residents from themselves. How does one do that when such residents are prone to violent behavior?

I think the issue before you in many ways is quality of care. I think the one thing that I quite often miss in these discussions is that people forget who the care givers are. The care givers are certainly not this committee, not the Ministry of Health, not even the administrator of a nursing home, or the nursing home association. The care givers are the nurses aides at the bottom of the heap who do the day to day work. And that's what we miss in this legislation.

Turning to the bill of rights in Section 2, we applaud the good intent of the drafters of this proposed legislation where it concerns the well-being of residents. However, we have some serious misgivings about the wording of a number of clauses. How, for example, can a nursing home be operated in such a way that the physical, psychological, social, cultural and spiritual needs of each of its residents be adequately met? Is this not an impossible requirement? After all, who determines precisely the needs of the residents, particularly where it concerns their social, cultural and spiritual needs? Again, I bring that back to who the care giver is.

Meeting those needs, however important that is, takes time, and time, quite frankly, is what our membership does not have. If we are going to have these kinds of goals, we also have to give people the tools to do it with. Section 2, subsection 2(8) states, "each resident shall have the opportunity to pursue his or her social, cultural and other interests and to develop to his or her potential." What happens if a nursing home cannot possibly accommodate the "social, cultural and other interests" of

certain residents? Do residents have the right to insist on having a tropical garden, a score of domestic animals, et cetera? What will happen if having an aquarium constitutes a health hazard for a mentally unstable resident? We are simply raising these questions to alert your committee to the potential conflicts that will undoubtedly occur if the amendments are not tempered with certain restrictions and do not take into account some basic limitations of a nursing home. I would say "any institution".

We also wish to voice our reservations about the provisions of Section 17e and 17f in the proposed amendments. The powers of the residents council advisory committee, and particularly the residents council advisor, are so widespread that any unfounded charges against nursing home staff and operators can do substantial and even irreparable damage to the reputations of the people involved. This is particularly true when certain ideologically motivated pressure groups manage to obtain seats on such councils. We would much prefer a public complaints commission appointed by the government that will investigate any reported wrongdoing away from the glare of publicity.

And I think that at this point, you do have to appreciate that as far as staff is concerned, there is a bit of paranoia, I think, that has infiltrated the private nursing home industry, certainly amongst the operators, and that has filtered down to staff. There is a lot of tension in nursing homes, a lot of questions that are asked of us as to what our rights are. What happens if this doesn't happen? What happens if a certain resident walks away from the nursing home? Who's responsible? There is a lot of concern out there by the people who actually give the care.

Giving such wide powers to a local advisory council leaves any nursing staff member wide open to innuendos and anonymous complaints which may lead to suspension, make the victim go through unnecessary suffering, even if in the end she is vindicated and restored. Again, there are several examples of people in the past whose reputations have been destroyed because of unsubstantiated charges. And in this instance, I can imagine that quite often the staff gets the blame. They feel like they're at the bottom of the pile.

Finally, we'd like to draw your attention to point four of the proposed bill of rights which states that each resident shall have the right to consent to the giving or the refusing of medical treatment or medication in accordance with the law, and shall be given the opportunity to obtain an independent medical opinion concerning any proposed medical treatment or medication.

It would appear that the drafters of the proposed amendments are insufficiently aware of the mental

impairment or disability of a large number of residents in nursing homes. It is unrealistic to state that each resident shall have the right to consent to the giving or refusing of medical treatment or medication, for the simple reason that many residents are not capable of rational judgment in these matters. Under these amendments, residents suffering from schizophrenia or any other mental disorder would have the right to refuse medication. Such refusal could have serious consequences, not only for the resident but also for the staff of the home. We propose that this section be amended to the effect that the right to refuse medical treatment and medication rests only with residents who in the opinion of the doctor are mentally capable to make such a decision.

There are many provisions in the new amendments that we wholeheartedly endorse. It is certainly not our intent to be only critical and negative. We do believe that the points mentioned in this brief warrant serious reconsideration and redrafting.

Thank you.

MR. CHAIRMAN: Thank you, Mr. Beekhuis.

We have had real problems in terms of our time. The committee unfortunately was not formally charged with the responsibility for this at all, and it's the last day of the sitting, and actually we had to make up a list of people that we thought we should contact, and Mr. Andrewes provided us with your association's, and I think we made contact with Mr. Vandercot on Friday around the same time as you apparently read the papers. So we wanted to make sure that you were one of the invitees, given the time frame that we had to deal with. And we understand the constraints that has put on various organizations around the province, but we did also want to make sure we got this Bill through before we got back to the House.

Questions from the members? Mr. Andrewes.

MR. ANDREWES: Thanks, Mr. Chairman.

Mr. Beekhuis, you said forty-seven health care institutions, your members are employed in forty-seven health care institutions; what types of institutions?

MR. BEEKHUIS: All types. We have private nursing homes, nonprofit, charitables, even municipal homes.

MR. ANDREWES: But when you say health care institutions, you are speaking primarily of nursing homes, homes for the aged?

MR. BEEKHUIS: Yes, that sort of thing.

MR. ANDREWES: Rest homes as well?

MR. BEEKHUIS: Yeah.

MR. ANDREWES: Let me just pursue for a moment the question of reasonable grounds, and I ask Mr. Johnson's view on what constitutes reasonable grounds.

MR. CHAIRMAN: Mr. Johnson?

MR. JOHNSON: Well, it's difficult to argue with the description used in the brief.

MR. ANDREWES: Do you mean it's a "weasle word"?

MR. CHAIRMAN: The joy of lawyers?

MR. JOHNSON: It's certainly a joy of lawyers, yes.

In fairness, it's one of those words that in a sense is well-known to law in that a court is comfortable with that word, but defining it in advance is difficult. I mean "reasonable" I suppose is what would be considered reasonable, set out objectively. I mean the average person would say yeah, that's reasonable; that's probably your definition. But I must concede that you can't control all the nuances of that. But essentially, it tries to set an objective: a reasonable person's standard.

MR. ANDREWES: Is there any better way to define it?

MR. JOHNSON: Well, it is unfortunate or unfortunately, you know, widely used in criminal or penal or a variety of statutes like that. That's why I say it is a concept that's well known to the courts and the law. And that's why it was used here. It's difficult to think of a more appropriate word or phrase.

MR. ANDREWES: Do you have any better way to describe "reasonable grounds", Mr. Beekhuis?

MR. BEEKHUIS: Well, I have been involved in litigation long enough to know the basis of this kind of language. I think you might be better served by language which deals with the opposite side in the sense that it's done without mal-intent, or something to that effect, rather than "reasonable", because I think certainly our membership is very concerned about on the one hand being obligated to report things, and on the other hand, being placed in a situation where you may have to defend yourself. And then you are not going to get many complaints. And I think that's not the kind of thing that you are looking for.

MR. KUNTZ: In fact, today we are faced with many situations where, as my colleague indicates, there is almost a paranoia on behalf of the operators, and it reflects very much and they really feel conned. And it's hard to answer those questions, particularly where we've had several recent cases where people were fired entirely without cause, entirely, entirely; circumstantial, no proof, good people that you personally know too. You know what I mean?

Of course, mistakes are made and they have to be dealt with, and we tell that to the operators as well. We're afraid of this and we want to get out of this situation.

MR. CHAIRMAN: Mr. Andrewes?

MR. ANDREWES: Thank you. I guess we'll leave the weasle word for a moment.

You have suggested as an alternative to putting the onus on the employee for reporting abuses, you have suggested that the onus remain on the administrator of the home, and that failure to make these reports carry the necessary penalty. Who's going to report to the administrator?

MR. BEEKHUIS: I think certainly staff can. I think the one thing I do miss in the whole business of the amendments is that there is very little mention of the person who's doing the care. And I think it's all nice for everybody on the outside to be able to come in and have their two bits worth put into the process, but if you are leaving out the person who is actually doing the care, I think you have missed the fundamental step.

MR. ANDREWES: I guess that was one of the purposes of the section, and that was to, first of all, to put some onus on the person giving the care to make reports, if those reports are necessary, and on the second side of it, and you know, we can argue about the whole term of "reasonable grounds" to protect them from reprisals, if in fact they do make those reports.

MR. BEEKHUIS: I guess the problem is what happens if a staff member does not have knowledge of a certain case? That's a whole side of it too.

MR. ANDREWES: Well, how do you clear the air then? How do you make it -- how do you create a situation in which employees, care-givers as you describe them, can feel free to make a report; you have suggested to the director, without that fear of reprisal?

MR. BEEKHUIS: I don't know how you are really ever going to get away from that in the sense that it takes a

fairly strong individual who is fairly self-confident in their position to be able to make those kinds of allegations. And they have to be quite serious or they are simply not going to do it.

Any employer, no matter where you work, has ways and means of making your life miserable, and there is no way that legislation is ever going to be able to deal with that. The only thing you may be able to protect them from is termination or suspension.

But I think it's well-known that you can mess around with work schedules. You can do all kinds of things, if it really gets that far. Certainly in our situation where they are covered by collective agreements, they have access to the grievance procedure. In a home where there is all the -- where there is no recourse, I suspect you are not going to get too many complaints. Certainly, I think it has to be anonymous if it's going to happen.

MR. ANDREWES: Okay.

Your point about the funding and the inequity of the funding and the disparity between municipally sponsored homes for the aged and nursing homes; I couldn't agree with you more. We are surprised that it's not addressed in this Act, but we will hope for better things in the future legislation I guess.

But down to the bottom of page whatever, three, you talk about the difficulty in handling patients, residents who are demented or unstable, you describe them. You say that staff members are often called on to intervene and take measures to protect the residents from themselves.

How does one do that when such residents are prone to violent behaviour? That's a subject, of course, that's up for some debate in the news media today where O.P.S.E.U., I believe, have actually laid charges against a mentally retarded man who has the mentality of a five year old, according to the report. They have laid charges of assault against this particular patient to draw attention to the concerns that they have about their members and the difficulties that it places their members in, relative to caring for patients of that type.

I wonder if I might ask Mr. Johnson whether or not there is in law protection for employees who find themselves in these kinds of situation?

MR. CHAIRMAN: Mr. Johnson.

MR. JOHNSON: Well, sir, there is in labour law -- it's an area I don't pretend to be terribly familiar with -- but I think the witness has indicated some of the difficulties there given to protect against discharge. And

in fact the Union organizing that sort of thing, there are specific provisions in the labour law. But as he points out, some of the more subtle things are rather more difficult to control.

MR. CHAIRMAN: Have you ever used in your union the right to refuse, if you feel consistently a patient has been unsafe and a danger to staff?

MR. BEEKHUIS: Of course, that's quite easy to do when you are working at a stamping machine, but when you are working with human beings who need care, that's very difficult to do.

I was at a membership meeting last night in the Golden Horseshoe area, and there was one particular resident that was mentioned last night at my membership meeting that is about twenty-nine years old. He is mentally all there. He is physically obviously not. He is living with people who are in their eighty's and ninety's who are demented. He is so frustrated that he has been trying to kill himself for the last year. Staff has to deal with this type of a person.

I think a lot of it comes down to simply staffing levels. And I think what has to be done -- and in the blue brief that you have before you, we are proposing that there is a whole different way of funding, that the funding has to go along with the resident. So that if you have certain residents who are heavy care, the funding will automatically go with that resident.

I think this per diem and flat fee approach is a blunt-axe approach to the whole business. If a home is full of heavy care residents, they are automatically going to receive the heavy care funding for the residents that they have. But in order to do that, you have to set up a rather finely tuned classification system which is directly attached to the funding.

Because we are running into situations now even where residents are being swapped, and it's like a bit of a marketplace. You know, "You take two of my heavy residents and I will take one of yours," and it's terrible. People get ripped out of their communities.

I think that the whole issue of funding has to be looked at in relationship to the amount of staff that a place can have. Nobody is asking the government to throw money at it without strings attached. The province of Alberta for example has given increases of up to twenty per cent in funding. They have attached that directly to the staffing levels. Because if you are going to meet the needs that we are talking about here, or you are going to deal with the difficult resident, that person has to be

dealt with somewhere. It's either in a nursing home at sixty bucks a day, or it's going to be in an active care facility for three or four times that amount. They are going to have to be dealt with.

No matter what facility they are in, we are going to need more staff to deal with them, obviously. If you are going to handle someone like that, you have to have two people. Now, we're talking about situations in nursing homes where the ratio is sometimes as bad as one to fifteen. That's at best assembly line care. That does not give any time to meet -- it meets their physical needs, but I daresay that these other lofty goals which are in the legislation are not going to be met. And the legislation isn't going to give that to them.

And there is a certain reality in demographics that in the next thirty years we are facing. Four per cent increases aren't going to cut it. And it's unfortunate, but that's the kind of world that we're facing, and I think the government at a certain point has to come to grips with that.

MR. CHAIRMAN: Mr. Andrewes.

MR. ANDREWES: I was trying to find the section in here that deals with the patient's right or the resident's right to refuse to take medication.

MR. CHAIRMAN: Mr. Johnson.

MR. JOHNSON: Sir, that's in the statement of principles, and it's page three, item four.

MR. ANDREWES: Could you, Mr. Johnson, comment upon the difference between the statement of principle, which becomes, under subsection 3, becomes part of the contract between the resident and the nursing home, how in fact is the employee protected under those circumstances? How, in fact, is the administrator of the nursing home protected under those circumstances, if in fact a patient does decline to take medication and that patient's health is affected by that decision?

MR. JOHNSON: In this situation -- if we are talking about a competent patient, I'm assuming?

MR. ANDREWES: Yes.

MR. JOHNSON: We have ---

MR. ANDREWES: I would assume so. But the brief talks about the patient suffering from schizophrenia and other mental disorders. But are you talking about competent or incompetent?

MR. BEEKHUIS: I don't think the legislation even says anything about whether the residents are competent or not. At this point, I think that certainly has to be something that has to be amended to the Bill.

MR. JOHNSON: Yeah. Clearly, number four contemplates a competent person refusing treatment, and one of the things that we are proposing in the regulations to cover that off is that in such an incident, it must be reported and recorded by the administrator, at minimum.

If it's possible, people would undoubtedly like to have that consent in writing. Because if a competent person is refusing treatment and then does suffer, there is always the possibility of their coming back upon me. So, as I say, our proposal for regulation then is that at minimum it will be an incident that will be recorded by the administrator, presumably a witness at least.

MR. ANDREWES: Okay.

In the case then of an incompetent patient, this right of refusal would not be granted?

MR. JOHNSON: Well, I have to say, sir, it's not addressed by this. I mean, clearly you have a further hurdle to overcome, that how will that right to refuse treatment be dealt with? Will that person's representative be able to do it or not? And that is not addressed here.

MR. CORDIANO: Will that be addressed in the Mental Health Act? Would that have any bearing on this?

MR. JOHNSON: It's certainly addressed in that Act but not in a way, I believe, that would affect this.

MR. CORDIANO: I thought we could kill two birds with one stone.

MR. CHAIRMAN: Mr. Andrewes?

MR. CORDIANO: Sorry, Mr. Andrewes.

MR. ANDREWES: Just one final question: Is it appropriate to have incompetent patients in a nursing home setting?

MR. SAPSFORD: It's in my view unavoidable.

MR. KUNTZ: They're certainly there, and lots of them.

MR. JOHNSON: If I may, Mr. Chairman?

MR. CHAIRMAN: Mr. Johnson.

MR. JOHNSON: I think what you tend to get, from some of my own experience, is people who are, as it were, in and out. They're not people who are necessarily incompetent, but from time to time they are. Certainly my father-in-law's experience was that.

MR. ANDREWES: Thank you.

MR. CHAIRMAN: Mr. Cooke.

MR. COOKE: Just following up on this, on the last page of your brief, your suggestion is that the Act should be amended so that I guess the home doctor would have the ability to declare whether somebody is mentally able to make a decision of whether they should take medication or not.

I am just wondering, I mean, with all of the discussion this Legislature has had over the years about the Mental Health Act, why would we treat residents of nursing homes in any other different way? I mean, under your proposal there would be no right to appeal. A patient would be labeled as being competent or incompetent simply by the decision of a home doctor. Don't you see that the implications of that are that we are treating residents of nursing homes in a completely and entirely different way than we would treat any other segment of our population?

MR. BEEKHUIS: I think that's an issue that we haven't probably fully addressed. I think it certainly has to be addressed by someone outside the resident himself. I am not quite familiar with the Mental Health Act that much that I know exactly what the regulations are in that regard.

MR. COOKE: Out of the brief, I have a question for Mr. Johnson, and it has to do with the Section 17 again and the complaints and the clause about unless the other person acts maliciously or without reasonable grounds. How is that enforced? If I make a complaint that is malicious or is without reasonable grounds, I am then subject to the fines under this Act. Who is going to lay the charge against me?

MR. JOHNSON: I'm sorry, now; I want to make sure I have it:

The employee or visitor has made a complaint without grounds....

MR. COOKE: Right.

MR. JOHNSON: ...without reasonable grounds. Who is going to ---

MR. COOKE: Who is going to charge me, and so forth?

MR. JOHNSON: Presumably that complaint was made to the Director, and so the Director would have -- I mean, he would have the option, as it were, to lay a charge or not lay a charge.

MR. COOKE: So the Director of the -- so the Ministry of Health itself could potentially be put in a position of laying charges against people that make complaints about nursing homes?

MR. JOHNSON: That's conceivable.

MR. COOKE: The more you look at that section, there has got to be something done about that. Can you imagine the implication of the Minister of Health laying a charge against a citizen or an employee with a fine of up to \$10,000, perhaps being convicted, and all the press coverage that would be received as a result of that? No one in their right mind in the community would ever phone the Minister of Health with a complaint again.

MR. CHAIRMAN: Any further comment, Mr. Johnson?

MR. JOHNSON: I think, Mr. Chairman, I want to think about that one for a moment because I am not certain that my answer is right. If I could dwell on that, I would like to get back.

MR. CHAIRMAN: Perhaps you would like to respond either this afternoon or Monday to Mr. Cooke's question?

MR. JOHNSON: Yes, if I may, sir. Thank you.

MR. CHAIRMAN: I have a somewhat related question regarding the individual who reports someone who has acted improperly against a patient. There was a suggestion in one of your responses earlier that people should be able to make those reports anonymously. Is there anything in the Bill that would prevent them from doing that?

MR. BEEKHUIS: No, I suppose not, not in this particular legislation. But it's something that they certainly need some kind of an assurance of, because you are not dealing with people that are used to doing those kinds of things. We have complained in the past on their behalf. We don't work there: We can afford it; they can't. And I guess that's the concern that we raised.

MR. CHAIRMAN: It occurs to me that that might happen more often than less often, that that employee would make an anonymous report to protect himself from being accused of maliciously charging a fellow employee. At the same time, if it was documented, or even without

signature, there would certainly be some kind of record that the act had been reported and some protection might be provided. But that's just a lay comment.

Are there any further questions? If not, thank you very much for coming and making your presentation.

MR. COOKE: Could I raise a point?

MR. CHAIRMAN: Just before we get to Mr. Cooke's point, I'm advised that in response to a question placed earlier this morning about the number of nursing homes that had a residents council, that the Nursing Home Branch did a survey about two years ago that showed 325 out of 333 homes had those councils; 325 of 333.

Mr. Cooke?

MR. COOKE: I was just wondering, we had a discussion yesterday about the fact that the Minister wasn't here on the opening day. This morning we are proceeding with public hearings on a bill, and not only do we not have the Minister here, but we don't even have the Parliamentary Assistant.

UNIDENTIFIED: (Inaudible)

MR. COOKE: Well, I don't care. You are a member of the committee just like I am, but you are not representing the Ministry.

When we proceed with legislation in the House, we don't proceed without either the Parliamentary Assistant or the Minister. And I think it would be appropriate that at least one representative, so that when there are policy questions that come out of the presentations, that we're able to ask the policy questions. We can ask the technical questions to the representatives from the Ministry, but we can't ask policy questions.

MR. CHAIRMAN: Mr. Cooke, it's unfortunate that neither Mr. Elston nor Miss Hart is here this morning. I was not aware of the fact that Miss Hart wouldn't be here until I arrived this morning. I have since spoken to her office and suggested that she should be present whenever the Minister is unable to be so, and I shall convey your concern to her as well.

MR. ANDREWES: And mine.

MR. CHAIRMAN: And Mr. Andrewes'.

Anything further? If not, the Committee stands adjourned until 2:00 P.M.

The Committee recessed at 12:08 p.m.

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STANDING COMMITTEE ON SOCIAL DEVELOPMENT

NURSING HOMES AMENDMENT ACT

HEALTH FACILITIES SPECIAL ORDERS AMENDMENT ACT

THURSDAY, FEBRUARY 19, 1987

Afternoon Sitting



STANDING COMMITTEE ON SOCIAL DEVELOPMENT

CHAIRMAN: Johnston, R. F. (Scarborough West NDP)

VICE-CHAIRMAN: Allen, R. (Hamilton West NDP)

Andrewes, P. W. (Lincoln PC)

Baetz, R. C. (Ottawa West PC)

Callahan, R. V. (Brampton L)

Cooke, D. S. (Windsor-Riverside NDP)

Cordiano, J. (Downsview L)

Cousens, W. D. (York Centre PC)

Hart, C. E. (York East L)

Jackson, C. (Burlington South PC)

Reycraft, D. R. (Middlesex L)

Substitutions:

Davis, W. C. (Scarborough Centre PC) for Mr. Cousens

Newman, B. (Windsor-Walkerville L) for Mr. Callahan

Also taking part:

Hart, C. E., Parliamentary Assistant to the Minister of Health
(York East L)

Ramsay, D. (Timiskaming L)

Clerk: Carrozza, F.

Witnesses:

From the Ministry of Health:

Elston, Hon. M. J., Minister of Health (Huron-Bruce L)

Johnson, J. M., Director, Legal Services Branch

Sapsford, R. T., Director, Nursing Homes Branch

LEGISLATIVE ASSEMBLY OF ONTARIO
STANDING COMMITTEE ON SOCIAL DEVELOPMENT
Thursday, February 19, 1987

BILL 176 - AN ACT TO AMEND THE NURSING HOME ACT
BILL 177 - AN ACT TO AMEND THE HEALTH FACILITIES
SPECIAL ORDERS ACT
(Continued)

The Committee met at 2:05 p.m. in room 2.

The Chairman: Call the Committee to order.

Dealing with Bills 176 and 177 around the Nursing Home Act amendments, one procedural matter.

Concerned Friends, that was scheduled for this time, has provided us with copies of their brief which is a fairly detailed analysis and critique, if you will, of the Legislation. They are providing it to us though on the basis that it be done only to the members of the Committee and that it be kept in confidence until they actually make their presentation next week.

So I will distribute it to all members who feel they can manage that; that is, to keep it to themselves and not make it public so that we are not stealing their thunder when they make their presentation next week, other than put it out under all names.

Mr. Cooke: If it's good, we can just rewrite it and put it out in longhand.

The Chairman: That's right.

Ms. Hart: Might I say that that would be very helpful to the purposes of amendment.

The Chairman: I think so too. So if that is in agreement, we will first of all distribute that to the members and the Minister so you have that available for you.

And we were able, therefore, to make time for the Minister to spend some time with the Committee and have an exchange between the members on matters coming from the two Bills and the opening statement that was made by the Parliamentary Assistant a few days ago now.

Do you have anything that you want to open up with or do you want to go into question and answer?

The Hon. Murray Elston: Mr. Chairman, I was told I should be here by the Committee and I am here. The Committee was in receipt of the opening remarks by my able Parliamentary Assistant who is spending the time in the

Committee because of the problems in scheduling that I have.

The Committee sets their schedule and I have schedule difficulties as well. So Christine Hart will be spending the bulk of the time in the Committee and when I have the opportunity, I will be here as well. So I am here.

The Chairman: Let's open it up then. Would either of the critics come forward. Mr. Andrewes?

Mr. Andrewes: Deal with Mr. Cooke for the moment.

The Chairman: Mr. Cooke?

Mr. Cooke: Perhaps I can just go through some sections of the Act to try to get a better understanding of what was intended. The questions have been forward --

The Hon. Murray Elston: You are going to do it clause by clause, you mean?

Mr. Cooke: No, no, no. I don't want to do clause by clause because my amendments aren't prepared yet.

I was just going to ask you, because I knew you had several amendments in preparation and I was hoping that you would make them available at your earliest convenience.

The Chairman: He has already committed himself to do so.

Mr. Cooke: We have done that and we were just hoping that you will do the same thing.

I'd like to ask the Minister just the reasoning for the fundamental principles being fundamental principles rather than a Bill of Rights and an explanation of, how under his proposal, these principles are enforced.

The Hon. Murray Elston: Well, they will be enforced, David, as you know, the way we do things now in terms of the regulations to the Act which set out the manner in which various services are provided and, of course, there are penalty sections in the Act which can be relied upon to act as an enforcement section.

Mr. Cooke: Okay, but my understanding, from what we have been told is that the fundamental principles would likely form part of a contract.

The Hon. Murray Elston: Yes, they would show up as included as part of the contract, a statement of the manner in which the facilities should be operated and the ability of the people to look to those as a contractual relationship at a civil level with the operators.

In addition to those statements of principle, obviously, the rounding out of the Act, which is always the case, will be done by regulations and the regulations, of course, will be setting specific areas which can be checked out and violations written for any problems which arise with enforcement -- sorry, the enforcement would then call on us to write out violation notices and then enforce them under penalty sections.

Mr. Cooke: What I don't understand is, if that forms part of a contract, then obviously the responsibility of enforcing the contract is with the residents?

The Hon. Murray Elston: And that is at the civil level and there is always the situation which is open in the statutory requirements to enforce this. There is also, in most cases, a situation where there is a civil opportunity in addition to the one that's provided by it.

I do not think it is usually done, but the big thing is if we are going to do it, we should do it for everybody now.

If all the press want to put their microphones up here, we should let everybody do that.

The Chairman: Is there a problem? If not...

The Hon. Murray Elston: I just want everybody to have the same chance, that is all.

The Chairman: Sure, that is fine. Does anybody else need access to --

The Hon. Murray Elston: No, they don't.

The Chairman: They are all right. Okay.

The Hon. Murray Elston: Just so that everybody knows that the discussions are not privileged here.

Where were we?

Mr. Cooke: So one aspect is that the residents are not responsible for enforcement?

The Hon. Murray Elston: There will be a civil situation which is always the case in situations where there are services being provided, obviously, but we have an enforcement provision under the statutory requirements which will be the focus of the regulations and others.

That is, in the case of a lot of civil matters, any violations which are cited and prosecutions which are involved will become evidence, of course, in the civil

matter, at least the indication that certain things are happening can be useful in civil proceedings.

Mr. Cooke: But it is not determined there. I think I want to just look carefully at some of the wording.

When you use the words:

"...are operated in accordance with the following principles..."

that the implication of that is that these aren't absolute guarantees, that they are principles, which I don't think sound as firm as...

The Hon. Murray Elston: You don't hold your principles firmly?

Mr. Cooke: Well, I think you know what I mean. We have had presentations before the Committee that express the same kinds of...

The Hon. Murray Elston: But the regulations will become much more specific, Mr. Cooke.

Mr. Cooke: We don't have the regulations, that's the difficulty, so we don't know what the regulations are going to say.

The Hon. Murray Elston: My difficulty, of course - and you will remember earlier discussions about this very item - my concern is that if we were to draft the entire regulation system for a Bill that was proposed and then end up going through the same stuff as we did with 54 and 55, it becomes a waste of material.

Mr. Cooke: Well, I have heard that explanation, the difficulty...

The Hon. Murray Elston: Well, you have heard that explanation, but I ask that you recognize what happened with 54 and 55, so not only have you heard that explanation but you in fact assume it is in effect.

Mr. Cooke: The difficulty for us is you want us to pass judgment on legislation which by and large gives you huge amounts of regulatory power and we are supposed to pass judgment on that and you don't give us the regulations, even though we heard from legal counsel this morning that some of the regulations are being worked on. I mean, that's being damn hard on the Committee.

The Hon. Murray Elston: Well, they are concepts which we have to look at but until we have these sections how can you expect us to be specific in the regulations?

Mr. Davis: Well, if they are concepts they should be

shared with the Committee.

The Hon. Murray Elston: They are concepts and until we have the section, how can you expect us to be specific in the regulations, David?

Mr. Davis: You were specific before 55, Mr. Minister.

The Hon. Murray Elston: I wasn't, but I can tell you about the concept. Mr. Davis recalls it, of course, but the sections were about 80 per cent changed.

Mr. Davis: I notice that, I expect to see the same in this one.

The Hon. Murray Elston: Let me get back to a question that I asked this morning. An 80 per cent change in the Nursing Home Amendment Act would be of some interest, so if you want to start suggesting, Reverend Davis, what those changes are so that we can take a look at your drafting, that would have been of help to us.

Mr. Davis: Our sections are here.

The Chairman: Strange, but I am sure Mr. Cooke had the floor and I will put the Reverend on afterwards.

Mr. Cooke?

Mr. Cooke: This morning I asked for an interpretation from Mr. Johnson about Section 17 of the Bill and the complaints that can be filed and the wording of:

"Unless the other person acts maliciously or without reasonable grounds... "

and I was wondering who is responsible for enforcing that?

In other words, I file a complaint with the Director, there's a determination by somebody that my complaint is malicious or is without reasonable grounds, therefore, I've violated this Act. Who is responsible for enforcing that?

The Hon. Murray Elston: Well, the situation which we are looking at is a case of protection being provided to somebody from an activity of reporting and if, in fact, somebody takes action against an employee that was well founded, obviously they, that person who takes the action is going to be in violation and would be in violation under the terms of this Act. So that would be a violation which we would write up under the Nursing Homes Branch, obviously.

Mr. Cooke: So if there was a determination that there was a complaint that was malicious then you would raise the subject?

The Hon. Murray Elston: But ultimately the

determination, the subject matter would be determined under the court process.

Mr. Cooke: Yes.. My concern, obviously, and I think this is an extremely important point--

The Hon. Murray Elston: Yes?

Mr. Cooke: --that what you are basically saying is that if there is a complaint that may be determined as being malicious, and it could come from an employee or it could come from a...

The Hon. Murray Elston: A resident.

Mr. Cooke: Or a resident or it could come from just a concerned citizen?

The Hon. Murray Elston: Yes.

Mr. Cooke: That potentially the Ministry of Health could be laying charges against that individual and I wonder if...

The Hon. Murray Elston: Or get somebody who inappropriately took action for dismissal or some other things.

Mr. Cooke: ...and I wondered...

The Hon. Murray Elston: The other item is that presumably, under those situations, if it is an employee involved, for instance, there would be grievance procedures as well.

Mr. Cooke: Yes, I understand that, but there is a fair number of non-union nursing homes.

The Hon. Murray Elston: That's true.

Mr. Cooke: The concern obviously is that if all this would have to do is happen once that a citizen in Ontario was charged by the Ministry of Health under this section, it would get great play in the press and the media and the message to everybody in the province would be, don't complain because so and so was charged.

The Hon. Murray Elston: You can speculate to that event.

Mr. Cooke: You don't think that would be the message, that that could potentially occur?

The Hon. Murray Elston: You are speculating on that, David, and it's very difficult for me to speculate along with you because your vision in these areas is much more

dynamic than mine.

From my standpoint, we would take a look at each situation. We have to carefully weight what, in fact, has happened and engage a response. In that situation that's what we do.

Mr. Cooke: So you don't think that's a danger and you have included it in the Act?

The Hon. Murray Elston: Well, it doesn't seem to me, from my standpoint, that we would act in a manner which was capricious or otherwise. Our intention is obviously expressed...

Mr. Cooke: That's not the point. I'm not suggesting the Ministry wouldn't be fair. What I'm suggesting is the message after one charge is laid would be a very negative message to people and we want to encourage complaints.

The Hon. Murray Elston: Okay. If I can complete my statement. I think that you have to understand that we wouldn't be acting in a capricious nature, particularly in that situation.

We have expressed within the amendments as set out the indication that we would like to have the most open system possible in terms of having complaints laid and, from our standpoint, the balance there has to be a balance of some sort with respect to the manner and how that is done.

Now, that having been said, there obviously would be to ensure that the process was interpreted to promote the lodging of complaints in appropriate circumstances.

Mr. Cooke: Would you indicate to...

Mr. Andrewes: Are you moving to another subject now?

Mr. Cooke: Yes.

Mr. Andrewes: I just want to clarify what your interpretation of the word "forthwith" is under that reporting section.

The Hon. Murray Elston: What section is that?

Mr. Andrewes: 17(a)(1).

The Hon. Murray Elston: 1?

I think it probably means in the same lingo that usually goes to as early as practicably possible. I don't like to have situations where there is inordinate delay, obviously.

Mr. Andrewes: A report coming three months after the fact you would not deem to be forthwith?

The Hon. Murray Elston: I don't know what the circumstances are that you are talking about, but I think, from my understanding, the best time to take a look at a question of abuse is obviously as soon after the event as possible.

Mr. Andrewes: Well, can I take you then, Minister, back to the early fall or mid-fall when Concerned Friends made some statements relative to alleged abuses in nursing homes?

The Hon. Murray Elston: Mm-hmm.

Mr. Andrewes: And the response we got at the time from the Attorney General, and I believe from yourself, was that some of these alleged abuses took place two and three and four and five...

The Hon. Murray Elston: Some time earlier, yes.

Mr. Andrewes: And I assume then all of the activities related to that section which deals with reporting then have some limitations placed on them, if the report is aged or not made forthwith?

The Hon. Murray Elston: What we're trying to indicate is that the best time for us to act is as soon after it has occurred.

Mr. Andrewes: I agree.

The Hon. Murray Elston: And from that standpoint, if somebody has not made a complaint in a manner which is timely so we can investigate at the time, from a practical standpoint, it has very little possibility of us providing a positive resolution to investigation.

Mr. Andrewes: I guess what I'm concerned about is: Is the reporter going to be held responsible to the same degree as set out in Section 17 if -- I guess I need some indication of what the limitation is in terms of...

The Hon. Murray Elston: You mean you want a limitation period and definition of "forthwith"?

Mr. Andrewes: Yes.

The Hon. Murray Elston: Well, usually what is determined to be "forthwith" is as reasonably practicable after the event.

Now, what that is, is under the circumstances - and Jack is much more recently inclined to analyze any case law than I - but it really means, under all the circumstances, whenever the first reasonable chance was available that people should report, and there's a personal assessment there and obviously some subjective things that are used to measure the event after the fact, but it's a flexible measurement and you have to take a look at all the circumstances. You can't say, for instance, the report must be made within 20 minutes or an hour or whatever. I don't think we can be that specific.

Mr. Andrewes: No, I guess, it's the other end of the scale that I think I need the limitation perhaps more precisely ascribed.

The Hon. Murray Elston: Well, some of the items that we are talking about here are things -- are a series of actions which may amount in total to a person arriving at a decision that an abuse has occurred.

And though, you know, from the first time that they made their observation might be some time removed from the ultimate time when a decision is made, I have just got to know what the circumstances and details are to really assess what you're talking about.

Mr. Andrewes: I think that's what I'm getting at. If a complaint was made -- if I was a resident and made a complaint today and someone in the next room, knowing that I have made that complaint said yes, I remember a year and a half ago a similar circumstance where an abuse took place...

The Hon. Murray Elston: Mm-hmm.

Mr. Andrewes: ...what sort of limitations are going to be placed on the evidence?

The Hon. Murray Elston: The evidence? Of course, the evidence is always weighed in a court of law. There are various particular situations which weigh the evidentiary material that is put in front of a judge. Those are really well defined and are well-known by legal counsel, obviously, and the relevance and the level of influence of pieces of information are always weighed in a court of law on the basis of when they were generated, the credibility of the presenter, any number of areas, and that is well controlled by an extremely wide body of evidentiary casework and also the Evidence Act itself.

Mr. Andrewes: What about the reverse on this thing? What does this Act do to that person who has failed to report?

The Hon. Murray Elston: How do you mean, what does it

do? The indication is that if they don't then they have violated the section.

Mr. Andrewes: Yes.

The Hon. Murray Elston: Yes.

Mr. Andrewes: And in the case that I cite...

The Hon. Murray Elston: You're talking about the person who was there a year or so before?

Mr. Andrewes: Yes.

The Hon. Murray Elston: It may have been a situation in which-- on reasonable grounds, which is why there has to be a reasonable situation that it did not appear to that person.

The circumstances, however, may have built over a period of time in which a person was then able to make some connections which, before they were known, was unable to act. In those situations, again the evidence would indicate what was required and also with respect to the manner in which these statutes are enforced.

An inspection group would obviously be required to make some judgments about whether a person was withholding information, refusing to report in a knowing manner, having no other -- you know, you just have to deal with it on that basis. Having no other way of dealing with it, you have these circumstances to weigh and those sorts of judgments will have to be made.

The Chairman: Do you have another question?

Mr. Andrewes: I was going to ask whether anybody would be advising a witness bringing forward that information of those circumstances and the ramifications. of...

The Hon. Murray Elston: Would there be counsel or something available, you mean?

Mr. Andrewes: Yes.

The Hon. Murray Elston: Well, in that situation I suppose that a person can always seek independent advice. Having seen certain things and knowing the scheme of the operation, I'm sure that people would be able to assess the level of advice that they would seek.

We also have a situation where a call can be made directly to the Ministry if that's the route chosen. Many people call us directly to the Nursing Homes Branch now to

make contact, to indicate concern or whatever and we then pick up on those calls.

At the same time there could be use of any other number of informal areas, whether that would be in terms of situations where there's an organized workforce in the workplace, it might go very well to the stewards or to executive members or to association members or whatever.

There's always personal counsel, obviously, and if there's concern in the sense of, you know, what do I do, the idea of having the Residents' Council available just to bounce things off, or to have an adviser not to act as an enforcement mechanism, but to provide people who are searching - if you didn't happen to be a staff person or whatever - people who are searching for information, I'm sure that they could be steered in a direction which would help them get their questions answered.

Mr. Andrewes: Thank you.

The Chairman: Thank you, Mr. Andrews. Back to Mr. Cooke.

Mr. Cooke: I'm just wondering if we could get an indication-- we know what's happened in the last few days with Country Place. I'm wondering, since that's a pretty good example of what has happened under the old Act and under the -- since this problem first existed, at least to our knowledge, 1983, and it's taken four years to get to the point where the nursing home was actually taken over, charges laid against the home, on-going violations of the Act with offers to or attempts - but the ability for the home to come into compliance and those opportunities being given to the home time and time and time again, I'm wondering if the Minister could indicate to us what, under the new legislation, would change what has happened with Country Place?

The Hon. Murray Elston: In the Country Place situation there were and are extended periods of time for coming into compliance and I think that the amendments would allow somewhat more flexibility to the Board who is reviewing this to set more concrete limits for people coming into compliance rather than leaving them as open as they are now. That, in my mind, would be an improvement.

Mr. Cooke: But the philosophy of the Branch, of the Nursing Home Branch is still going to be: An inspection takes place, a violation of the Act is determined and there's an opportunity to come into compliance and then a plan is submitted, a re-inspection takes place; there may be another opportunity to come into compliance.

I mean, a lot of this, I assume, may not even be the

Act as much as what the philosophy of the Ministry is and how they deal with the violations of the Act. The impression we got from your Parliamentary Assistant yesterday was that the philosophy has not changed, that they don't want to deal with any of these matters in a confrontational way and that opportunities, on-going opportunities to comply will continue. And, in fact, there's sections of the Act that restate that, that you will be giving homes on-going opportunities to comply with the Act.

The Hon. Murray Elston: That's correct, there will be on-going opportunities. In fact, we have indicated that the style of inspection has been changed in terms of allowing people who first go out to inspect as being consultants to assist people, actually to deal with problem areas in a home and they will act in a consulting fashion to make sure that they can improve fairly quickly the operations in those homes and, if required, will then notify of problems and peoples' unwillingness, perhaps, to come into compliance to an inspector who would be in charge of issuing enforcement notices.

That sort of thing is, I think, designed to do two things: one, it's designed to remove the initial contact tensions from a person who is at one and the same time initially seen to be a consulting person: How do I improve the question/answer to the guy who says: Are you going to issue the summons to me type person.

And so we have actually removed or separated those two into two different inspection procedures under two different people. We look at that as probably being the most constructive way of getting things moving and keeping them moving in the local area where there may be a violation of some sort present.

Upon any inspection time, for instance, it's not unusual, I think, for somebody to have a report and find that perhaps there's been a fire door which has been propped open perhaps and they will say, you know, don't do that, and come into compliance with that order and not prop that door open, that that door is to remain shut, for instance.

If there's a problem in ventilation or whatever the problem might have been, then they can say: Listen, okay, let's do that, but tell me how to do X and they can do that.

And I think that that's a constructive way of having dialogue between people in the Ministry and the people who are operating the home, whoever they may be, to make sure that there are ways of keeping the environment for the citizens controlled and acceptable for good living.

Mr. Cooke: But in this particular...

The Hon. Murray Elston: And if there was a continuing problem then, of course, you'd go to the second people who would then issue an order for at least a violation.

Mr. Cooke: In this particular home, though, it wasn't a matter of the inspection branch not picking up the violations, it wasn't a matter of even the inspection branch or the Ministry not laying charges because, as you know, in '83 there were -- sorry, October '85 there were 19 violations; in '84 there were 39, and in '83 there were 30.

In October of '85, that would have been the first year of which you were Minister, there were violations that included residents call systems not operational, no activity for dependent residents, mold growth and dirt in the fridge and freezer, walls and floors throughout dirty and sticky, urine odours, meal areas not cleaned, dried food and uncleaned dishes, snacks not being served and therapeutic meals not being served. Those are not doors not being propped open by -- I mean, they are not minor violations.

The Hon. Murray Elston: I agree and that's why the action was taken in terms of revocations procedures.

Mr. Cooke: But what I'm confused about is that was in October of 1985. In January of '86 charges were laid against the home and in 1984 there were 14 charges, and in 1983 there were three charges.

So here we have a home that has clearly violated the Act to the point where they were charged, appeared before a court, numerous complaints were brought to the Ministry's attention by Concerned Friends, by my predecessor as health critic, by the Union that was out there and even by my leader who visited the home; all of which had been substantiated as legitimate complaints, yet it took four years to get to the point where, even though it's clear that these violations were putting residents at risk -- I mean, therapeutic diets, if you're not following therapeutic diets you're putting somebody at risk; if there's mold in the freezer, that's potentially putting people at risk, and dirty kitchen and so forth. Why did it take four years -- and I understand you weren't the Minister for the whole time but you were the Minister for the last 18 months.

The Hon. Murray Elston: Well, our procedure was initiated when we found that they were not providing the follow-up to the compliance plans which they filed and we took the steps that were required and we gave them the time that is required under the current statutes.

It's my opinion that this is a tighter procedure, in fact, allows a hearing Board more flexibility in determining whether there's been adequate time and, in fact, probably

tightens the procedure up.

Mr. Cooke: So until recently then, until this action -- your Ministry was satisfied that over the last few years, even though there were charges and there were compliance orders written, that this home was co-operating in terms of coming into compliance after the compliance orders were written?

The Hon. Murray Elston: I can't comment, I guess, on the previous time. All I can tell you is that we took steps when it became evident that they were not. We took steps in August, we followed up on those under the procedure that is allowed for us to do the work and ultimately we decided to take the action that was indicated earlier this week.

Your comments about the feeling of the Ministry of Health in '83 and '84, I can't comment on that, but I can tell you what our feelings were and the action that we took and the fact that it was the action which was appropriate under the statutes and I can only tell you about that.

Neither Mr. Sapsford nor Mr. Johnson were with us in those early days and I can tell you that we have done what we did, as reported to you, in compliance with the regulatory regime and we think that there's an improvement under the amendments which are being proposed here in allowing decisions to be made about the appropriateness of delay and complying with filed plans and other things.

Mr. Cooke: But there's a reiteration of the same policy?

The Hon. Murray Elston: Yes, there is time being allowed for cleaning up the non-compliance areas and, in fact, the bulk of our people, when they have things pointed out to them, move to change.

The Chairman: Just for a couple of other members of the Committee who may not be as familiar with the new Act as the two of you are.

What is the new section that you are talking about, about the possibility of moving faster? I'm just interested to know.

Mr. Johnson: Well, one of the important sections is one that was alluded to briefly yesterday which is -- if you have the Bill in front of you and you look at page 9 -- it's sort of a two step because in the middle of the page subsection 8(2) of the said Act is repealed, and then at the top of the page, the item called 4(a) is what replaces it.

And what happened before was that the process which the Minister has described of identifying the problems,

trying to get the people to fix it up, finally you decide they won't fix it up then you go to Board. Then the existing section, in effect, tells the Board to allow them time, so the Board allows more time.

So, in effect, you've had a double allotment of time and it's what we faced in the Country Place situation where the Minister launched the revocation proceeding in August 15th, 1986. The Board meets to have its first meeting around the beginning of October and at that time determines well, in accordance with the Act, we must give these people time, three months seems reasonable. And so they set their next date eventually for February 3rd.

Mr. Cooke: What I don't understand is, why wouldn't the Act be amended to say that if the conditions in a nursing home are a threat to a resident, if the physical or whatever conditions are such that a resident is in danger, why would we even put in the Act the philosophy that the nursing home should be given the opportunity to comply?

I can understand minor violations of the Act, that if there's a tile on the wall broken, sure, they should be able to correct that situation. But if you have got mold and you have got unsafe conditions and dirty walls and urine odours and meal areas not cleaned, surely to God we shouldn't be giving a nursing home the opportunity to comply.

They have violated the Act and they have threatened the life of senior citizens, of residents of nursing homes, so why would we institutionalize the philosophy that they should be given the opportunity to comply? They have broken the law. They shouldn't be given a second chance to put people at risk.

The Hon. Murray Elston: That's the whole point of having the inspection crew go in though and say: Look, there are certain things that you are not doing properly, clean them up and get them, so that they don't put people at risk.

Mr. Cooke: But they already have.

The Hon. Murray Elston: We have to get those items cleaned up.

Mr. Cooke: But they already have put people at risk.

The Hon. Murray Elston: You're asking us, I guess, to say that without any due process...

Mr. Cooke: No, that's not what I'm saying. What I'm saying is that that's not due process to give a person a chance to clean up after the inspector's determinant. Due process is you lay a charge and you go to court and the

judge will decide whether the Ministry is right or the nursing home is right.

What you are saying is: No, we don't lay a charge, we give them an opportunity to comply and then if they don't comply we might lay a charge or we might give them the opportunity to comply again. That's not due process, that's stupidity in terms of putting people at risk.

The Hon. Murray Elston: Well, that's -- I mean, you've expressed your opinion on that. When problems arise the first step is to make sure they're corrected and if they can be corrected, then that is what we like to see happen.

Mr. Cooke: It still pays to break the Act. It still pays to break the Act under that philosophy because you might as well break the Act, cut back on your staff, cut back on food, don't clean up the nursing home because you're going to be given the opportunity to comply, to comply with the Act, and during the time that you've been able to break the Act you've been able to save money. That's what it boils down to, it pays you to break the Act under that philosophy.

The Hon. Murray Elston: Well, I don't think it does pay to break the Act but I will accept your interpretation of that material. I'd like to say that the steps we have taken have been designed, first and foremost, to get us into position where we can act in a consulting and encouraging role to make sure those people, who are residents, are taken good care of, and if we require it, then we'll move in and use the court procedures to enforce the Act.

We had, as you well know, some difficulties in the specifics of veteran regulations and I know that those things are also being fixed up in a manner which will allow us to move perhaps a little earlier with a little more dispatch. You know, I don't know that in each circumstance that -- what you are trying to suggest is that if there's a sanitation problem, if people are -- I don't know, if it's a bad, bad situation that we ignore it until there's compliance.

Mr. Cooke: If a person is not getting a therapeutic meal, if a doctor has ordered a therapeutic diet and the nursing home is not following the therapeutic diet, I think you would agree that the resident has been put at risk. Why wouldn't there be a charge laid, why would there just simply be a compliance order written?

The Hon. Murray Elston: Well, in this situation, presumably a charge would have been laid in those circumstances. I don't know...

Mr. Cooke: You know that doesn't happen.

The Hon. Murray Elston:of all the times that...

Mr. Cooke: That doesn't happen in 90 per cent of the occasions.

The Hon. Murray Elston: We have the authority to lay a charge if the person is at risk. I think that's clear to us. I don't know, under the circumstances, of all the times obviously it goes on.

Mr. Cooke: You don't. You don't.

The Hon. Murray Elston: But there is a situation where an inspector does have some discretion with respect to the manner of dealing with what they find in those areas. That being the case, the seriousness of the violation obviously determines what response that inspector will make.

Mr. Cooke: Here's an area of non-compliance for this nursing home, Country Place.

Several care plans reviewed were not modified, revised to show change in care needs due to deterioration. Lack of co-operation during personal care which required -- I can't read all of this, it's not copied well -- anyway, a series of infractions of the care plan and this is in 1985.

And there's a compliance order and it's accepted, so there's no charge laid, but a person's basic care plan is not being met and all that happens is a compliance order is written. There's no charge laid against the home, and this is a home that, in 1985, already has two years of a horrible history and this is during your time as Minister.

The Hon. Murray Elston: Under the circumstances, obviously, the inspector made a determination but that doesn't mean that the inspector doesn't have the authority to lay the charge.

Mr. Cooke: I know he has the authority. I'm saying to you that it's a policy decision and you're keeping the same policy that was followed by the former government.

The Hon. Murray Elston: To allow the inspectors to examine the severity of the situation and make a determination.

Mr. Cooke: No, to allow that you always write up a compliance plan first instead of determining if, in fact, a person is put at risk and it's a serious infraction of the Act, then there's not an opportunity to comply, obviously they have to comply, but there's a charge laid as well.

I mean, as I say -- have you read these, the annual

inspection reports for Country Place?

The Hon. Murray Elston: Mm-hmm. I've had the opportunity of looking through those in more detail recently.

Mr. Cooke: Well, you must see that this home has four years - four years that we know of - and Mr. Baetz asked yesterday what the history of this home was before 1983 and Mr. Baetz would know that the reason we don't know the history of this home before 1983 is that previous to 1983 annual inspection reports were kept secret.

It was only in 1983 that they began to become public documents, but this is a home that at least has four years and maybe a longer history of horrible care and we still followed the philosophy in these three annual inspection reports of writing up compliance orders rather than laying charges.

The Hon. Murray Elston: But that doesn't...

Mr. Cooke: Do you think that that philosophy is okay?

The Hon. Murray Elston: There is the area of ability to write up charges at the same time.

Mr. Cooke: I'm not saying there is not the ability, I'm saying you're not doing it.

The Hon. Murray Elston: What you are saying is that the inspector should be told that there is no flexibility, all requirements for compliance orders must also generate a charge.

Mr. Cooke: I'm saying that when there is a serious violation of the Act, a charge should be followed, yes.

The Hon. Murray Elston: That's a fair comment.

Mr. Cooke: Even the Ontario Nursing Home Association said that that would be appropriate yesterday.

The Chairman: I wonder if perhaps we can move to another member and then come back.

Just for my understanding and, again, I'm not as up on the difficulties between the old and new Acts as perhaps the critics are. Essentially, am I gathering we are not changing anything in terms of compliance orders...

The Hon. Murray Elston: It can still be written.

The Chairman: That stays the same?

The Hon. Murray Elston: A person can still lay a charge at the same time as non-compliance is found.

The Chairman: I am looking at Country Place and I'm looking at the fact that in October '85 we had our last inspection and there were major problems identified and it's not until the next August that the Ministry determines that there hasn't been a sufficient attempt to comply and then you make the approach to the Board for the further action which then causes the revocation order in February of '87 and I gather there's some...

The Hon. Murray Elston: No, sorry. The Board met in between that and they said that it would be appropriate, since they are required to give some time for compliance, to give them time for compliance.

The Chairman: So there's a period...

The Hon. Murray Elston: Intervening, yes.

The Chairman: So when they meet in the fall there's a further compliance time period given?

The Hon. Murray Elston: Correct.

The Chairman: And then in February they are convinced and the Ministry is convinced that has not occurred and so you...

The Hon. Murray Elston: No, I was convinced.

The Chairman: You were convinced?

The Hon. Murray Elston: Correct.

The Chairman: And, therefore, you would take revocation action at that point and I gather we were told that there was sort of a hearing happening in March.

The Hon. Murray Elston: March 3rd through to the 10th.

The Chairman: Sometime after that the whole thing will be completed. What I wasn't understanding from what you were saying to Mr. Cooke is in this new section that Mr. Johnson read to us, what parts...

The Hon. Murray Elston: The Board might say, for instance, that you have already received a reasonable opportunity of complying, therefore, we'll go ahead with the hearing.

The Chairman: I was looking at the Country Place

thing and the scenario we have just been through and saying: At what point does that section come into play? How much actual time would have been saved, say, on this particular case with this new action? At what point do you think the Board would hear...

The Hon. Murray Elston: When it first heard the case they might have said: Appropriate time has been given for compliance, none having occurred we will go ahead and hear it.

The Chairman: So like last October then, about a year after the initial inspection report they would have, at that point, been able to say there's been sufficient time and so at that point you could have done the revocation order?

The Hon. Murray Elston: They would have gone directly to the hearings, for instance.

The Chairman: So six months?

The Hon. Murray Elston: So a saving of about six months.

The Chairman: Instead of a year and a half?

The Hon. Murray Elston: Or four months.

The Chairman: I see.

Mr. Cooke: So it's still a long time.

Mr. Andrewes: It's better than over a year.

The Chairman: Mr. Andrewes?

Mr. Cooke: I would just like to table this with the Clerk. Yesterday we got some information, a study that was conducted in Alberta that would indicate that there was no difference between non-profit and profit homes.

I want to give to the clerk a list of studies that have been conducted that prove the opposite.

The Hon. Murray Elston: Can I? Technically, you probably should have a witness do that. There is no tabling at Committees.

Mr. Cooke: This is just a list of documents that people can take a look at in the record.

The Hon. Murray Elston: How are we going to put them in the record?

Mr. Andrewes: They don't get into the official

transcript unless members read them and what happens is, for instance, like the Hyde report we were just sent and provided yesterday, I presume by the Ministry, worries about the government...

The Hon. Murray Elston: It's a request of the Ministry for information.

THE CHAIRMAN: And this is a member volunteering something for us. Okay. It will be an exhibit under the name of Mr. Cooke.

The Hon. Murray Elston: Can we cross-examine him on it?

The Chairman: Absolutely. You can take the next hour and a half to get at Mr. Cooke on this list of bibliography.

Mr. Andrewes, we'll give you some time here.

Mr. Andrewes: Thank you, Mr. Chairman. I was following with some interest the line of questioning of the Minister. Have you found the Hyde Report?

The Hon. Murray Elston: I was just trying to get it straight who was volunteering what I understand we're volunteering to provide, the Hyde Report, as a result of being mentioned yesterday by one of the presenters.

The Chairman: That is right, on the question from Mr. Andrewes.

The Hon. Murray Elston: Okay. Sorry, I needed some clarification, Mr. Chairman.

The Chairman: Okay.

Mr. Andrewes: Yeah. There's no mention of or no intent to mention payment plans in this Act.

The Hon. Murray Elston: No intention to mention...?

Mr. Andrewes: Payment plans.

The Hon. Murray Elston: Payment plans?

Mr. Andrewes: No intention to deal with the inflexibility of the current payment system.

The Hon. Murray Elston: That's not true.

Mr. Andrewes: Tell me where, so it's not true?

The Hon. Murray Elston: Well, there's a section that allows us to purchase special services which is authorized

under the amendments proposed.

Mr. Andrewes: Well, I'm coming to that. I'm coming to that.

The Hon. Murray Elston: Well, that seems to me then to indicate that you're not right. There is an intention to deal with the "inflexible system" that you had just underlined.

Mr. Andrewes: That doesn't deal, Minister, with the position put forward yesterday by one of the witnesses, that in the mix...

The Hon. Murray Elston: Which one?

Mr. Andrewes: I don't recall.

The Hon. Murray Elston: Okay, sorry.

Mr. Andrewes: The mix of patient load in a nursing home. Certain patients require more care than others and as that patient load becomes weighted on the side of heavy patients, that the funding mechanism does not address that situation.

The Hon. Murray Elston: It may very well be in a situation -- I understand one of the witnesses yesterday, I think, perhaps the President of the O.N.H.A. currently had indicated that he operates an Alzheimer's program in one of his and he felt that that mechanism would be available perhaps to allow him some flexibility.

I can see a situation where particular programs might very well be the subject matter of contractual relations which would provide some flexibility in having staffing levels or is in the situation with the activation program which we're contracting for to allow people to spend more time with residents and deal with the question of more service. I think it will provide us with some flexibility there.

Mr. Andrewes: The section that you're referring to, I'm not sure I know which one it is.

The Hon. Murray Elston: I know it's in here. I'm not sure which one.

Mr. Johnson: 10(3).

The Hon. Murray Elston: 10(3) I'm told of the Bill, page 10.

Mr. Andrewes: Your intent there then is to deal with situations where there is a heavy patient load, where there

may be special circumstances within a home that requires extra services.

Are you saying yes yet?

The Hon. Murray Elston: Well, there could be special programs that are requested, any number of circumstances might transpire. We end up having a situation, for instance, that we have asked people to indicate, by contract, that they will be providing activation programs and we'll provide them with an amount of money to accommodate that as long as they contract and actually deliver the service. We have indicated an amount of moneys available if the facility contracts with us and actually delivers a service for staff training.

Mr. Andrewes: Yes.

The Hon. Murray Elston: So we have indicated that if a home contracts with us and actually supplies incontinence care that we will provide them with extra amount of moneys to deal with that.

Those are specific programs that we want to see provided for people who we recognize require new needs and different needs and it seems to me it provides the flexibility to answer the requirements for new programs.

Mr. Cooke: None of that is required under the Act now.

The Hon. Murray Elston: None of that is required...?

Mr. Cooke: None of those things that you just listed off are required under the Act or the regulations.

The Hon. Murray Elston: Those are programs that we wanted to see introduced and we are prepared to pay for, when services are provided, so we, in fact, are using that mechanism for an enhancement procedure.

Mr. Cooke: That's not what I asked, but I am sorry.

Mr. Andrewes: Ask it again because I'm interested in the response.

Mr. Cooke: What my question was, is: None of those services are now required under the Act.

The Hon. Murray Elston: It's not recognized, I guess, as an area in which a lot of priority was given. We were providing that for extra -- for enhancement. Some people say...

Mr. Andrewes: Incontinence care? Incontinence care?

The Hon. Murray Elston: Incontinence care, that's right. We were providing this as an enhancement to let people deal with a question which they said was causing them problems.

Mr. Cooke: We are going to have to bribe them to provide that.

The Hon. Murray Elston: Or recognize the fact that there is an increased cost, that's in all homes, it's not just in particular specific homes.

Mr. Cooke: So you know what this amendment says. This amendment says:

"Provision of services in addition to those provided under this Act."

So what you're saying is, that any of these services you're going to buy for are not required under the Act and are contemplated to be required under the Act.

The Hon. Murray Elston: And they could be departures from the original thought to the Act, that's for sure, it could be brand new programs.

We'll be using them as a way of enhancing care in the facility and I think anything that allows us to do that is a generally good step forward.

Mr. Cooke: This is looking worse every day.

Mr. Andrewes: How are you going to make the decisions relative to these programs?

The Hon. Murray Elston: We will take a look at what is being provided in terms of input from the community and from the people who operate the homes and from residents' advisers.

Mr. Andrewes: Which community?

The Hon. Murray Elston: Community in the broadest sense.

Mr. Andrewes: Yes.

The Hon. Murray Elston: I mean we have people who represent various constituencies in the community, people who represent Alzheimer's patients, for instance, people who are involved as advocates like Concerned Friends, United Senior Citizens of Ontario. We get written material from just individual citizens. So the broadest community input and then we will take a look at what is required in terms of developing these programs.

Mr. Andrewes: How is this section going to help levelize the quality of service throughout the system?

The Hon. Murray Elston: Levelize?

Mr. Andrewes: Yes.

The Clerk: That's a new verb.

The Chairman: We know what you mean.

The Hon. Murray Elston: You mean make sure that there's equity in the system?

Mr. Andrewes: Yes.

The Hon. Murray Elston: It provides us with the fact that people can actually contract with us in circumstances that will allow them to provide services that they may have felt that they couldn't provide at the same level of care and we will enter into contractual arrangements which will help them provide those services.

Mr. Andrewes: And will the decision relative to the allocation of extra funds for these services be made arbitrarily, or on what basis will you make it?

The Hon. Murray Elston: That's a sill-- no, I won't say that's a silly question. I'm not saying it will be made arbitrarily.

Mr. Andrewes: There's nothing clear in here that gives me any comfort that it will be made in any other way.

The Hon. Murray Elston: I will undertake that it will not be made arbitrarily.

Mr. Andrewes: How will it be made then?

The Hon. Murray Elston: There will be an assessment of the contractual arrangements which will be required to be entered into and we will deal with it on a contractual basis, so it can hardly be made in an arbitrary manner.

Mr. Andrewes: My point about the arbitrariness of the decision-making would be this that: If in town A there is a request for a specific program, are you going to say that within that region there is no need for that specific program or that we have allocated sufficient resources for that type of program in that region? What sort of criteria are you going to use?

The Hon. Murray Elston: You know, I'm not sure what you are trying to get at in terms of this region or whatever. We will be dealing with individual operators of

facilities and those people will say: We would like to provide these services, under this arrangement. We are willing to get into this set of contractual arrangements and we will sit down and do it on that basis.

Mr. Andrewes: So you're saying it's wide open in terms of the individual homes, 300 and whatever?

The Hon. Murray Elston: That's true. And I think the other thing that I am interested in is the fact that in order to give us some levelizing that you were talking about, is the fact that the residents' advisers will be available in more than one centre and we will be able to exchange information among various of the Residents' Council groups about what is being provided in a particular home vis-a-vis what is being provided in the home they may be in at the time.

That being the case, that seems to me, from my standpoint, would be one of those levelizing abilities under the proposed scheme of amendments.

The Chairman: Surely it could be on a regional basis in that sense?

The Hon. Murray Elston: In terms of the adviser, you mean?

The Chairman: Yes.

The Hon. Murray Elston: Yes, but the funding -- I don't want to leave the impression that there would be \$1500 or something for southwestern Ontario and then the first come would get \$1500 and it's all gone. I think that's what you were suggesting. No? No, okay then.

The Chairman: But the reason I have to worry about is it's almost a Charter case. If you have got an Alzheimer's victim in one home, the deponent who was here before us yesterday and which is getting special programming and special money because he's applied for it and you have got another Alzheimer's victim in another home in another area where there's been no application for it and you have got a real separation of quality of services being provided in various parts of the province.

The Hon. Murray Elston: There could be a movement to provide service in that situation. You know, I think we have certain particular facilities where those programs are available and looking at what the results are, obviously, we introduce them on that basis and we find out what is required, what is being provided, okay.

(Media approaches podium)

The Hon. Murray Elston: I guess we've got a tag team.

The Chairman: It's good to know some reporters work together.

The Hon. Murray Elston: That's right.

So there will be certain circumstances where we will have trial programs in initial phases of introducing those new programmings into a system. I think you would recognize that as well as I when we try and measure the results of programming, how they are provided, the form and structure under which they're provided.

So in certain circumstances, I guess, there may be programs which are being tried out, the pilot project base or whatever that we're being continually encouraged to use as a way of measuring programs which might see, for instance, as the Chairman just pointed out, an Alzheimer's patient in one area not having access to a program that is relatively new and that we're trying to work with.

I agree that that problem exists in the field, Mr. Chairman, but there are some things that we have to do to make sure programming is applicable...

The Chairman: I wasn't worried about the pilot project idea.

Mr. Andrewes: No, not at all. You talk about incontinence programs, for instance. You know, those are fairly basic to the care and...

The Hon. Murray Elston: But I think there's an indication that the funding available under the per diem was not sufficient enough for everybody to feel comfortable with their ability to provide it, so we provided a situation where, if they required enhanced funding for that, they could enter into a contractual relationship which showed that that money would go to provide the basic incontinence care program and we are willing to more than make sure that in fact that incontinence care program is being provided.

Mr. Andrewes: Every levelling -- is every licensed nursing home in the province going to be able to take advantage of this particular section to provide incontinence care?

The Hon. Murray Elston: They can take advantage -- every nursing home can take advantage of our current program which was offered and announced last September 16th. So, yes, every nursing home would have access to programming through this as well.

Mr. Andrewes: As long as they could verify that they're...

Mr. Cooke: If they didn't take advantage of this enhanced funding, does that then mean that they don't have to provide that service?

The Hon. Murray Elston: That may mean that they feel they have already got a system in place which provides it. As a number of people said, they did have it.

Mr. Cooke: I'm just wondering if we all agree that incontinence training is an appropriate service that should be offered in every nursing home...

The Hon. Murray Elston: Incontinence care?

Mr. Cooke: Care, yes. Then how would you enforce -- if that's a basic program in a nursing home and they're not accessing the funding, then you wouldn't possibly be able to say that they are violating the Nursing Home Act by not providing that service.

The Hon. Murray Elston: But if they weren't caring for the individual person or resident that part of his personal care program that you mentioned earlier.

Mr. Cooke: I guess I'm confused as to what is a basic requirement under the Act and, therefore, is part of the basic per diem that is being paid and what is some extra that you want to contract for.

The Hon. Murray Elston: I think, Mr. Cooke, though what we have been recognizing under the current regime is that it didn't take into account the fact that we have now considerably, on average, more frail residents in nursing homes than earlier and when the original question of funding was brought up and the traditional percentage increase in settlements of the per diem didn't always recognize the increased load that was required by a different mix as was brought out earlier by Mr. Andrewes of the patient load.

That being the case, we looked at incontinent care contracting as being a way of ensuring that the dollars which were given, the extra dollars which were given, would go directly into that program to make sure that there was an even ability to provide the service right across the province.

Mr. Cooke: I understood the rationale the day you announced it in the House. I'm still totally confused on how it's going to work and how it will be enforced.

The Chairman: Mr. Andrewes?

Mr. Andrewes: Well, I'm equally confused. The Minister knows that anyway. He's commented on my state of confusion before, but when one looks, for instance, at the fundamental principles in item 2:

"Each resident shall be properly sheltered, fed and clothed, groomed and cared for in a manner consistent with his or her needs."

And then you tell me that you are prepared to contract with a nursing home to provide extra money for incontinence care.

The Hon. Murray Elston: I used that as an example of a situation where we've already put a contract in place for those places that said that they were not able to work under the current per diem situation. This is something that will provide us with some "levelling" as you have described it. I don't think there should be any surprise about that.

What we are ensuring, however, is that in allowing the contract to be entered into is that we can follow the money directly into the program and it doesn't become a global amount.

Mr. Andrewes: Okay. Can we move on to the Residents' Advisory Committee. I guess I'd like to hear your views on the purpose of the Residents' Advisory Committee or the role, the role of the Residents' Advisory Committee.

The Hon. Murray Elston: Well, I mentioned, I think at the early part of this discussion, the fact that the Residents' Council was there to both advise and to examine and to be in the local area an informal watchdog, as it were, of people who would promote certain sorts of programs inside a facility.

A situation where they would interpret for a resident or a resident's representative what was going on, what programs were being provided, what the financial information that is posted may mean, would help people retrieve information if there were questions about detail.

All of that stuff is extremely important in helping people who are not in the facility every day understand exactly what is going on inside the institution would be their primary responsibility.

Of course, the enforcement of the Act is with us, with the Ministry of Health, but I look at the Residents' Council as an important way of keeping the residents involved, of activating them to that, where they're able, of keeping the representatives, whether that be a relative or personal friends or whatever or agents of the resident, informed and able to have access to information, and an important way of getting the people from outside the home - people who would be representative of the community, the broader community -

for instance, if there was a home in Lincoln, community representatives from the boundaries of Lincoln to be participants in understanding what's happening inside this facility which is providing service to the community.

So those are three very important components. The other important component is the fact that there might become a situation where information would be communicated to the Ministry of Health, it's always possible. It is not the primary role that it would play. It would also, I think, with an adviser - if we were asked to appoint one - allow people to understand what is happening around the area, for instance, in the broader area of the Niagara Peninsula or something, so that people could understand what services are being provided, how they are being provided, how the administration of a particular home may have been developed, to be more quickly responsive of residents' needs.

So there are several areas in which I think they can be very important and an enlightening influence on the operation of the homes.

Mr. Andrewes: So I take it from all of that that the Residents' Council Advisory Committee has no defined responsibility, it's...

The Hon. Murray Elston: Oh, it has a defined responsibility.

Mr. Andrewes: Its responsibilities are in terms of searching out and reporting?

The Hon. Murray Elston: Yes.

Mr. Andrewes: And it's responsibilities are not to enforce though?

The Hon. Murray Elston: No. The enforcement of this Act is ours, the Ministry of Health. We can't, from my standpoint, look at the group of advisers to be the "enforcement".

Mr. Cooke: Why would you put in the Act then, as one of the powers of the Committee:

"Receive and investigate complaints from residents and other persons."

The Hon. Murray Elston: Because it may be that they might be the first level that a person would go to. They might have any number of things which a resident might not...

Mr. Andrewes: Are you not creating an expectation?

Mr. Cooke: Sure are.

The Hon. Murray Elston: Then they can do it. I just wanted to give them the broadest opportunity to examine what was going on in their homes and if we said that they couldn't, they are not authorized to do something, then it would be my opinion that people would say: That's none of your business. But the primary requirement for enforcement of the Act rests with us, the Ministry of Health.

Mr. Andrewes: But I suggest to you that you are creating an expectation.

The Hon. Murray Elston: You are suggesting we take that out and we run the risk of a person receiving a reported violation as a member of the Residents' Council and saying: Listen, Mr. Administrator, we want to check into this and have the Administrator saying: It's none of your business because you don't have the statutory authority and I think that's a question about which we must discuss.

Mr. Cooke: The Nursing Home Inspection Branch.

The Hon. Murray Elston: Well, they may want to examine the veracity of whether or not the report should go on. It seems to me that when we are looking at whatever is being done by this council, that they have the broadest opportunities.

Mr. Cooke: Do you mean if they were to make a complaint...

The Hon. Murray Elston: If they were to make a decision that that, in fact, should not been done, then....

Mr. Cooke: A complaint can come in and they can determine whether or not that complaint goes to the Nursing Homes Inspection Branch?

The Hon. Murray Elston: They can get the background for it, they can do a whole lot of things, and it seems to me that if you want not to give them that authority, they should have a very long discussion about it to make sure that you are not limiting the amount of...

Mr. Andrewes: So they do have an investigative responsibility?

The Hon. Murray Elston: Yes, but not the primary responsibility. Obviously they can look into certain complaints about cold food, for instance.

Mr. Andrewes: But it's fairly primary. You're giving them authority to do all sorts of things and certainly you're giving authority to the adviser to do all sorts of

things which would....

The Hon. Murray Elston: To collect information, to investigate, that's true because his role as adviser will require him to have knowledge and information.

Mr. Andrewes: I would suggest to you to do more than collect information, to advise the Committee almost to the point of preparing a case.

The Hon. Murray Elston: Well, if that's what you're interpretation is. Are you suggesting then that we restrict him? Is that what you are saying?

Mr. Andrewes: I'm not quite sure exactly what you're looking for out of this Residents' Council Advisory Committee.

The Hon. Murray Elston: I'm looking for a very active involved organization of people who are concerned both as residents, as relatives of residents and as community people in ensuring that the home is operated in a manner which the community thinks is appropriate and in that sense we have to give them the broadest opportunities.

If there's a complaint that is laid, we have the responsibility, the Ministry of Health has the responsibility of searching it out, examining what's happening and what steps -- you know, laying charges if that is required.

Mr. Cooke: We may never hear from you, it will go to the Advisory Committee, they may determine that they don't want...

Mr. Andrewes: It's privileged.

Mr. Cooke: They might just stop it there.

The Hon. Murray Elston: Are you suggesting that the Committee people would do that? The person who goes to them can ultimately come to us anyway. We are not shutting off the route of a person, saying: I don't want to talk to anybody in the home I just want to call the Ministry. They can do that. In fact, people do that now and that direct link will not be taken away.

But at the same time, if somebody feels more comfortable, for instance, say you're visiting an elderly acquaintance and she says: Philip, I've had cold food these last three days. I mean, you might feel more comfortable about going to the people on the Residents' Council and say: Listen, my friend has indicated that this food is not getting to her in a warm condition, that in fact the soup is not what she ordered.

Mr. Cooke: They are advocates.

The Hon. Murray Elston: And you should know that, and can you tell me whether that's right or not and, you know, and if you don't know for sure, who can I go to to make sure it gets investigated. That type of role is a very important function.

Mr. Cooke: They're advocates, that's what you're trying to do.

Mr. Andrewes: I don't know whether they are advocates or not, but I think what you've done...

The Hon. Murray Elston: They are in a sense. They are not in your sense of going patient to patient, they are in terms of the home though, I think of looking at what can be done and they would promote what's best in the interests of the operation of that home from the residents' point of view.

Mr. Andrewes: You have created an expectation within this Committee from the residents' standpoint in terms of its ability to resolve matters.

The Hon. Murray Elston: The Residents' Council.

Mr. Andrewes: You have created an expectation by giving tremendous powers to the Residents' Council adviser which to me suggests it's taking the form of an adversarial situation where instead of informally trying to resolve...

The Chairman: Instead of what?

The Hon. Murray Elston: I want to ensure that there is some sense of quality in source and access to information and in being able to intelligently put the case to a person who is in charge of providing the service, and unless you allow the person the widest possible access to the information, you have some very difficult times of putting a case to the Ministry.

The Chairman: I especially enjoy conversations which cut each other off all the time, but I remind people that our poor transcribers are going to be trying to get down all of this stuff and that you guys finish questions or finish statements before the next question, whichever way it's going, to assist them.

Mr. Andrewes: Sorry. Well, I still have some extreme difficulty because, you see, what I think you've done is create within the Residents' Council Advisory Committee by giving -- by setting up this Residents' Council adviser, by giving the authority you have created expectation on the one

hand but you haven't given them any authority to finish the job.

Now, I don't think it's appropriate that they be the agent for the Minister to enforce the Ministry's rules and guidelines, but on the other hand you've given that expectation out to the nursing home community and I have some real difficulty with that.

Mr. Cooke: Do you have any more questions on this matter or are you staying on this topic?

Mr. Andrewes: No, go ahead.

Mr. Cooke: Okay. I'm a little confused by (h) on the list of powers of the Committee. It says:

"Carry out any other functions prescribed by the regulations."

Which means that if we pass that, we are giving you the right to convert these advisory committees into anything that you so desire to convert them to.

We have already got them as investigators, mediators and advocates and now we're going to give you the power to make them anything else you want to make them by regulation. Do you have any draft regulations on that section?

The Hon. Murray Elston: I don't have draft regulations on the section. I think the overriding regulatory decision is to allow people to be flexible enough to meet changing needs. If something comes up and there's a sense that the Residents' Councils have not the authority to do certain things, then it's nice to be able to sit down and say: Okay, let's discuss that and if it's appropriate to provide them with the authority under the regulation to fulfil that mandate. It's actually admitting that we don't know that the list is complete.

Mr. Cooke: I know.

The Hon. Murray Elston: There may be other things that they could accomplish if there were regulatory ability to do it. That's not unusual in allowing regulations to be drafted.

Mr. Cooke: The three people that are on the Advisory Committee appointed by yourself, could you tell us about what you seek for those people? Who is going to appoint them to...

The Hon. Murray Elston: Two, not three people. They would come as an appointment by...

Mr. Cooke: Obviously somebody locally is going to be

making some recommendations. How is that going to happen then?

The Hon. Murray Elston: Well, not necessarily. We don't necessarily have the details of information, how it would be done. It might very well come from a group, community group, they might be an auxilliary, for instance, providing some care in the facility, they might be a municipality, a municipal government that would be interested in having someone sit there as a representative or it could be just an individual.

Mr. Cooke: What role do you see for the Health Councils in there, this process of appointment?

The Hon. Murray Elston: In recommending, you mean?

Mr. Cooke: The long-term care committees that come out of the Health Council.

The Hon. Murray Elston: Well, the long-term care committees, of course, are dealing with items that are different than resident items. They are specific to the nursing home sector of Ontario.

Mr. Cooke: I realize that. What about them as people to appoint?

The Hon. Murray Elston: They might very well have recommendations. It might even be, in fact, somebody who is serving on a long-term care committee.

Mr. Cooke: I mean, I'm not advocating that since a lot of the long-term care committees are dominated by owners of nursing homes, but I just...

The Hon. Murray Elston: In some ways they certainly play an active role, but long-term care isn't only nursing home, it does comprise home care and other institutes.

Mr. Cooke: So you want us to pass that section and you can't even tell us any more today than you did when we had the lockup the day you introduced the legislation?

The Hon. Murray Elston: How do you mean?

Mr. Cooke: We asked these exact same questions in the lockup and we had no clearer answer then we've gotten today.

The Hon. Murray Elston: Do you want the qualification for...

Mr. Cooke: You haven't thought this through at all. You haven't thought this through at all. Who is going to appoint them, the potentially three advisers per nursing

home?

The Hon. Murray Elston: They would be appointed by the Ministry, that they would recommend people. We'd look at anybody that wished to apply. You know, we have to appoint people as it is under other statutes, and we get people who are interested. But it could be that a municipal government is more interested than another in having a representative. We take a look at...

Mr. Cooke: What about the Residents' Council adviser. These are full-time people, I take it?

The Hon. Murray Elston: Could be. Yes, that's right and probably will be, except that we don't know how many of the Residents' Council will request the appointment.

Mr. Cooke: Who will they work for?

The Hon. Murray Elston: They will be employed by -- the salary will be paid, obviously, through the Ministry.

Mr. Cooke: And they would be...

The Hon. Murray Elston: But they work for and under the direction of the Council.

Mr. Cooke: What kind of people are you looking for?

The Hon. Murray Elston: Well, it's a little bit like our patient advocate program in the psychiatric hospitals where we have a mixture of people who have interest. We have social work people, we have nursing people, we have some legal people who are involved and they bring together different perspectives and we have found them to be quite effective.

In this situation we'd be looking at qualifications which would vary as well. We are not looking at a licensed residents' adviser program so to speak if you know what I mean.

Mr. Cooke: Are you going to set up an office of the Residents' Council Adviser with somebody that's in charge province-wide?

The Hon. Murray Elston: Yes, we will have that co-ordinated through our Ministry.

Mr. Cooke: I'm just trying to figure out how and who this person reports to.

The Hon. Murray Elston: Well, they report actually to the Residents' Council. They will be responsible for dealing with the Residents' Council. The annual reports or

whatever will be required, will be lodged with someone in the Nursing Homes branch, presumably.

Mr. Andrewes: Can I just clarify something? Yesterday we were told that the system of advisers would be province-wide, that they would form the basis of an external group and would receive a block funding from the Ministry, but would be responsible...

The Hon. Murray Elston: You're talking about the report done through the Branch somewhere. Yes, that's right.

Mr. Andrewes: But they would be autonomous from the Ministry's operation?

The Hon. Murray Elston: But paid for through the Ministry's funding obviously and the component of how that report comes through and where it is flowed, the money flowed, is not in my mind of a critical nature. But my question was: How does information get back into us? Which really was what David was asking. The question of whether it would be a non-profit organization which acts as a central distributing area is another question, and it is one that I am quite interested in, but the reporting -- there has to be contact inside the Ministry in order to get the information fed back.

Mr. Cooke: I'm not sure whether you were rushed to get this Bill put together.

The Chairman: I have Mr. Baetz on my list as well.

Mr. Andrewes: Mr. Chairman, I share to a large degree the concern about the whole question of the Residents' Council adviser and the Advisory Committee. My final question is in terms of the statement that there should be a balance between private non-profit, private for profit and non-profit in terms of the issuance of the licences...

The Hon. Murray Elston: That the public interest is accounted for in the Act, yes.

Mr. Andrewes: What is the balance? What are you looking for? What criteria? When are you going to know that you've got the balance?

The Hon. Murray Elston: We will have to assess the circumstances. It's a reading which you will get on it. Right now most are not in the charitable domain, most are for profit. Most people who would like to run community-not-for-profit organizations felt that they had been shut out of the process because they didn't have track records and we are working to encourage those people in the

not-for-profit areas to come forward and we will assist them in making applications and putting together proposals in the sense of what is required in the documentation, in the documentation area.

We have also indicated that we will hold hearings away from the City of Toronto and make it a little easier for people who don't have as many funds available to flow a large scale presentation in the City and make ourselves much more available to them to do it in local areas.

So right now 5 per cent or 6 per cent, or whatever it is, that are not for profit doesn't seem to me to have indicated that there was a people access to the calls for proposals which have been issued in the past and we have just indicated that we will put the emphasis on making sure that there is that equality of opportunity and we're working on that now.

Mr. Andrewes: What is the figure you're aiming for?

The Hon. Murray Elston: I don't have a particular figure at this point. All I can say is that we are encouraging the issuance of more not-for-profit, if the programming accompanies the application.

Mr. Andrewes: Thank you, Mr. Chairman.

The Chairman: Mr. Baetz, you have been waiting patiently.

Mr. Baetz: Not at all.

Just to show you how close I am to my colleagues here, I was going to be asking a question too on the balance between profit and not-for-profit and especially in view of the fact that the Minister is, under this Bill, to be given discretion as to the proper balance and I guess discretion is a little bit -- that word is a little bit like reasonable, you know, we were discussing what reasonable means.

The Hon. Murray Elston: Do you want this to be reasonable discretion?

Mr. Baetz: It depends how you look at it or who you are, but we know it isn't indiscretion, but it is very vague really and it places enormous power in the hands of the Minister, it really does, and I guess that's the thing that leads to my questioning.

I was going to ask, for instance, the question that Mr. Andrewes raised about, you know, the minute you say that -- the minute that the Minister has some discretion then to achieve a balance between the profit and non-profit,

we heard this morning from one of the delegations that they didn't think there wasn't a proper balance at the present time, in fact they have indicated in their briefs that the Ministry should take whatever financial steps and incentives to really get more out of the homes under auspices of the not-for-profit.

But I really -- I also know, of course, that the Minister is going to wait for the very, very, wise report you're going to get out of the Select Committee on Health which is going to deal...

Mr. Andrewes: And Social Service.

Mr. Baetz: And Social Services, sorry.

The Chairman: I like the way Mr. Andrewes says that. I noticed he didn't wait.

Mr. Baetz: But anyway, I don't know. Would you like to just expand a little more on where you see you are going? Are you prepared to send out any signals at this point in time to the private operators or to the not-for-profit people? You must have some ideas. You must have some biases.

The Hon. Murray Elston: Yes.

Mr. Baetz: What are they?

The Hon. Murray Elston: I just indicated what we were doing to encourage are the opportunities for not-for-profit people to participate in the calls for proposals which have been made over the last several months.

For instance, one good example is the situation where not-for-profit organizations were actually provided with an allocation of beds, the operation of Elizabeth Greer. They are a 35-bed unit and also the startup of a multi-care component of the Woodrough Centre with a 35-bed allocation. Both those facilities, of course, are not for profit organizations.

Mr. Baetz: That's right.

The Hon. Murray Elston: And I have indicated in the calls in each of those situations that a preference would be given to looking at the not-for-profit organization. In each of the situations where we have had calls, that has been the criterion and the indication made.

That having been said, if I can compare - and I've done this before - with respect to two calls in the same vicinity in the province, that done for Cambridge and that done for Waterloo City, in that situation two calls for

proposals, one for 43 beds, Cambridge, another for 34 beds I think in Waterloo, we had various proponents and proposals. The winning proposal because of the service level was St. Luke's Place in Cambridge operated under the auspices of the United Church of Canada. It operates a very fine multi-level care facility which I attended and which is a very good facility.

In Waterloo, on the other hand, we had both profit and not-for-profit people applying and when we analyzed the proposals and the material put in front of us to deliver the service, we opted to go with the private operator in that situation and provided the 34 beds to, what's the name of the facility, Winston Hall. But the community recognized the input was that there was a good operation there and that in fact the services which were shown in the proposal and the understanding indicated in the proposal was superior as shown by that for-profit operation. So...

Mr. Cooke: How many beds did they allocate?

The Hon. Murray Elston: I don't know the total, David. We had announced more beds than have been allocated because we have had proposal calls, for instance, I think 70 for the Frontenac area not long ago and 70 for the Peterborough area not long ago. So 65 -- of those 70 beds maybe 60 in both of those places, I've forgotten.

Mr. Cooke: I'd like to get it clear as to how many beds have been allocated and how many -- you have counted them out - have gone out to non-profit?

The Hon. Murray Elston: For what period?

Mr. Cooke: You just started allocating beds, so since you've been Minister?

The Hon. Murray Elston: For what purpose?

Mr. Cooke: On the not-for-profit.

The Hon. Murray Elston: I can tell you the announcements that have been made and I can tell you that I was just indicating that there were clearly, for instance another 70 beds were allocated directly in Ottawa, not directly, but as a result of a call and we have indicated that there are 70 more beds there that are out for call, so they haven't been allocated.

Mr. Cooke: But of the ones that have been allocated at this point, how many have been not-for-profit and how many have been for profit?

The Hon. Murray Elston: I will give you that extension, but I can tell you that, for instance, in the

other two areas, the Kingston area and the Peterborough area, those calls are now out and haven't been -- not out, the people know that they're coming, they are alerted to the fact that an advertisement will be made at some time. I'm not sure when the one in Kingston is, this spring?

Mr. Cooke: These are updates? (inaudible)

The Hon. Murray Elston: (inaudible)

In any event, the chronicle thing is that the request for proposals will say there will be an indication that profit organizations will be given help and in fact their proposals will be reviewed sympathetically but that they have to meet the criteria of putting into place a proposal that is superior in its final analysis.

Mr. Baetz: I would just like to make, Mr. Chairman, finally the observation that having no statement on general guidelines, is it 75/20, is it 50/50, you know, in a broad way lacking all that, it gives the Minister enormous, enormous discretion and, I don't know, I think it could be quite worrisome maybe for the Minister as well as for the opposition.

The Hon. Murray Elston: You know, we have to make a decision of what's being provided with respect to concentration of ownership and we had a question in the House before we broke from -- I'm not sure whether it was David or whoever it was---

The Chairman: It was Mr. Rae.

Mr. Cooke: It was Bob.

The Hon. Murray Elston: Talking about certain chain operations in certain areas and the question of concentration. Those are all judgment calls. You know, in the end where I have to ultimately come down on anybody who answers a call for proposals, it's to take a look at what is being provided as a result of the answer of the programming that's involved, of the manner in which the facility will be operated and looking at what's going to be the best program to be provided for the residents and the undertakings that are given as result of that.

That's ultimately where we had, but in terms of the initial call we want to make it very clear that everybody will have an equal shot at it, to put in place a system whereby they can provide the best level of care that they can come up with under their answer.

Mr. Baetz: Thank you.

The Chairman: Mr. Cooke, another point?

Mr. Cooke: I'd like to get your understanding. It's hard to get your estimates. I'm not sure I understood. What specifically is the Ministry doing to help not-for-profit be able to apply for nursing home allocations?

The Hon. Murray Elston: I had given you some of the information earlier, but even today; for instance, we indicate in our advertisement that preference will be given to not-for-profit organizations. In the application we assist them at a practical level to allow them, whatever the organization is, to understand what the proposal call system or call for proposal is about.

What we anticipate seeing in terms of the way that the presentation is made, we have indicated that because not-for-profit organizations, generally speaking, have not been involved in operating homes that the fact that they have not operated does not weigh against them and, in fact, we look at what service they propose to provide and the manner in which they are proposing to provide it as the relevant issue.

We are decentralizing the hearing process for the issuance of licences. It used to be that everything was done in the City of Toronto which caused tremendous strain, as you can well imagine, on some of organizations coming down to make presentations, particularly when you have the not-for-profit organization as an out-growth of community response, whether that be as a result of seniors getting together or whatever, and I think the circumstances are such that the proposal may be assisted by the attendance of a number of the interested community parties who, I think, saw the issuance of these licences before an opportunity to go to accommodate a licence as outside their area having influence.

Mr. Cooke: Okay, but the point I'm trying to get at is, the things you have mentioned are practicable things that would be of some help, but what...

The Hon. Murray Elston: I think they are of considerable help, I mean, really.

Mr. Cooke: All right. Do you have people that are going out and talking to not for profit groups and telling them about the change in philosophy and what they have to do to apply?

The Hon. Murray Elston: We have been approached, I think probably the interesting thing about our situation now is that we have been approached by more community organizations and groups to allocate licences for specific operations than we have had nursing home beds to issue.

Mr. Cooke: What about the capital?

The Hon. Murray Elston: Just let me finish that one first. The community interest is extremely high in a number of areas, particularly communities where there has not been the presence of a home, for instance, in the Norwood area of the province, two organizations have at least made themselves known to me when I was down there. One is more of a citizens' group, the other is more of a municipal group, as I understand it. Those people don't need encouragement so much in terms of the interest, but they certainly do from the practical standpoint.

With respect to capital: We do not have capital funding available.

Mr. Cooke: What about the situation to access the market?

The Hon. Murray Elston: The only situation that the capital is available is under the LCAP Program which was the hooking of the Ministry of Health and Northern Development and Mines in a program which sought funding of smaller units to go into Northern Ontario communities.

Mr. Cooke: But what about -- I mean, how easy is it going to be for the not-for-profit groups to get at capital? Is it going to be...

The Hon. Murray Elston: Generally, I found them really quite able to generate the dollars for the capital side of it. Either they accommodate it by linking with some formal larger organization where there is capital available or they sat down and they have decided that they will raise it in certain manners.

Capital may be a problem in some areas, but a number of the very active people who have come to me promoting their interest, are people who know they can get a hold of the capital dollars. In some cases they, in fact, are people who already, as associations, may operate a seniors' complex, for instance.

Mr. Cooke: It might require the Ministry at some point looking at the least of guaranteeing some loans?

The Hon. Murray Elston: The money for capital has not been the biggest problem. At this stage, I think that you're right...

Mr. Cooke: That's an issue you will have to talk to Mr. Nightingale later about who said the major advantage of the private sector being involved is that they had access to capital and the not-for-profit sector couldn't get it.

The Hon. Murray Elston: Well, that hasn't been the major difficulty expressed to me. The major difficulty expressed to me was the obtaining of the licence. The opportunity to operate those licensed beds -- the difficulty - and I was about to say you're right on something and now I've forgotten what it is.

Mr. Cooke: It's so often you forget.

The Chairman: It's best that you forget.

The Hon. Murray Elston: When you got me in that other area. We agreed with the Ontario Nursing Home Association three or four times yesterday and I hate like heck to agree with something, I don't know why.

Oh, there was something -- that you are correct, that until now the concern is more on the information being made available to people that we will assist them, for instance.

The money doesn't always seem to be the biggest problem. There are arrangements made by these groups to find the money. Sometimes they make arrangements with corporate structures, to be quite honest, to work in some kind of a co-operative situation. I think of the hospital at Cambridge, for instance, it operates or is now just building in conjunction with the institute with how many beds, Ron? I'm not sure, 40 or 50.

So there's a situation where a community organization, the hospital in this case run by a Board, has linked up with a for-profit operator who will, I expect, provide the managerial skill inside.

The Chairman: Mr. Andrewes?

Mr. Andrewes: Thank you, I will pass.

The Chairman: Thank you.

Mr. Cooke: It's obvious that the Minister has read the transcripts from when Mr. Norton was the Minister of Health.

The Chairman: There is a lot of stuff coming in so, I mean, I use whatever techniques are at hand.

The Hon. Murray Elston: I can't help it if you guys are not interested in finding out what we are doing for the not-for-profit organizations. We are doing a lot of stuff and if you want me to cut it short I will do that, but Mr. Chairman, you are fully in command of this.

The Chairman: Again, as always, that's right.

There aren't any other questioners, so I think that will do for the afternoon.

Thank you, Mr. Minister for -- I thought you were just sort of getting into your rhythm.

The Hon. Murray Elston: I was.

The Chairman: I'm disappointed, but at this point there are others that are weakening before us.

On Monday we get together in Room 151 and then for the rest of the week we will be in 228, a slightly larger room than this, which I think might be useful.

Mr. Cooke: Are we itinerant?

The Chairman: But we are itinerant, there is no doubt about it.

I would like to ask the critics and the Government if it is possible to let me know the beginning of the week if you think you can have your amendments available on Thursday next. If you think that's possible, my recommendation would be that we would then not sit on Thursday, but distribute the amendments to the various parties, including the major deputants and then Monday following have a few of those major deputants' organizations come before us with their responses to the amendments and then on Tuesday start the actual clause-by-clause, if that's -- if it is not possible then let me know on Monday and we'll think it through otherwise, because it very well may not be possible.

The Hon. Murray Elston: Mr. Chairman, I appreciate what you are doing. I think that we will try to do that. The concern I have always in these situations is that amendments being proposed spawn amendments which are perhaps a consensus.

The Chairman: Yes.

The Hon. Murray Elston: And recognizing that I suspect all of us will be in a position where perhaps other interest is generated, but I think the earlier the better.

The Chairman: I think all we can guarantee to the organizations like the O.N.H.S. and the others is that they will get to see the first round of amendments from each of the groups involved and after that, as you say, the process moves too quickly and they will have to use the informal connection as we go through the clause-by-clause.

The Hon. Murray Elston: In this situation I think that these amendments being proposed as a package are so

reasonable that there won't be too much deviation, but, as always, you will always hear some unreasonable suggestions about amendments.

The Chairman: So we will probably be finished by a week Tuesday, I would guess, by the sounds of it. We are not having any difficulty at all. On that ridiculous note, we'll adjourn.

The Committee recessed at 3:50 p.m.

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STANDING COMMITTEE ON SOCIAL DEVELOPMENT

NURSING HOMES AMENDMENT ACT

HEALTH FACILITIES SPECIAL ORDERS AMENDMENT ACT

MONDAY, FEBRUARY 23, 1987



STANDING COMMITTEE ON SOCIAL DEVELOPMENT

CHAIRMAN: Johnston, R. F. (Scarborough West NDP)

VICE-CHAIRMAN: Allen, R. (Hamilton West NDP)

Andrewes, P. W. (Lincoln PC)

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Cousens, W. D. (York Centre PC)

Hart, C. E. (York East L)

Jackson, C. (Burlington South PC)

Reycraft, D. R. (Middlesex L)

Substitutions:

Davis, W. C. (Scarborough Centre PC) for Mr. Cousens

McLean, A. K. (Simcoe East PC) for Mr. Baetz

Also taking part:

Marland, M. (Mississauga South PC)

Clerk: Carrozza, F.

Witnesses:

From the Ministry of Health:

Hart, C. E., Parliamentary Assistant to the Minister of Health
(York East L)

From the Service Employees International Union:

Roscoe, S. E., Vice-President, Canadian Office

Van Beek, J., Director, Public Relations, Canadian Office

From the Ontario Coalition of Senior Citizens' Organizations:

Sugarboard, S., President

Purdy, S. G., Legal Counsel; with Scott and Aylen

Woodsworth, J.; President, Canadian Pensioners Concerned Inc., Ontario Division

Individual Presentation:

Franklin, Dr. A.

LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Monday, February 23, 1987

The committee met at 2 p.m. in room 151

Mr. Chairman: I call the Committee to order. This is the Standing Committee on Social Development regarding amendments to the Nursing Home Act, Bills 176 and 177.

We have three deputants before us this afternoon: Service Employees' Union, Ontario Coalition of Seniors' Organization, and a private citizen. We'll start off with the Service Employees' Union with Mr. Ted Roscoe and Mr. VanBeek.

Welcome.

The way we operate basically is for you to make your presentation any way you want to, and then we open it up to questions following that rather than interrupting it while you're doing it.

Mr. Roscoe: Thank you, Mr. Chairman and then we'll open up for questions.

The Service Employees Interntional Union wants to thank the Chairperson and members of the Social Development Committee for giving us the opportunity to address some of the concerns we have about the Nursing Homes Amendement Act, 1986.

SEIU represents 35,000 workers across Ontario. Approximately 95 per cent are public sector workers employed mainly in hospitals and nursing homes. We also have bargaining rights for school boards, race track employees, building maintenance services and manufacturing. SEIU is the largest union in Ontario in the private nursing home industry.

Our members working in nursing homes, as this Committee is well aware, have been subjected to many abuses over the years. A few years ago, contracting out our members' jobs to private employment agencies almost became the norm. Health care aids, nurses' aides, dietary aides, housekeepers and laundry workers were relegated to the unemployment and welfare lines because they were considered to be a too expensive commodity for nursing home operators.

When contracting out swept through the nursing homes industry like a prairie fire, we called it "morally reprehensible, illegal and totally callous," because it not

only put in jeopardy our members' well-being, but also the well-being of the residents.

Nursing home workers still are clustered around the \$20,000 per annum income level. More than 30 per cent work part time. Many are single parents; 99 per cent are women.

In retrospect, the issue of contracting out may have been a blessing in disguise for it heightened the public's awareness of the conditions in Ontario nursing homes. Contracting out showed that private profit always comes before people, whether it meant the care a resident received or the wages an employee got.

Nursing homes in Ontario are big business. It's a growth industry. Anyone having understanding of demographics knows the population is aging and services and care for the elderly will have to be provided.

SEIU took on the battle to fight contracting out and we won. Both an arbitration decision and an OLRB ruling stated an employer could not contract out its core functions, mainly the provisions of hands-on nursing care. We are proud of achieving increased job security for all nursing home workers, but we are also able to achieve better care for nursing home residents.

Invariably, contracting out meant residents were not getting the care they required. Underpaid workers unfamiliar with the care facility or its patients meant substandard services. Low pay rates encouraged high staff turn over. The lack of continuity of care hurt the residents.

The funding of nursing homes and the care nursing homes give are both public investments in the lives of the handicapped and the elderly. No one should have a right to make a profit on the backs of these people. Yet, of the 333 nursing homes in Ontario, 299 are operated as profit-making institutions. Even though the amendments to the Nursing Homes Act may be well-intentioned and strict regulations forthcoming, conditions the sick and elderly must live under in nursing homes will not radically alter until the welfare of the individual is deemed more important than the profit motive.

The Ontario government should move swiftly to reduce the number of for-profit nursing homes. In addition, the amended Act must be accompanied by strict, enforceable regulations that will give residents the mechanisms to deal with any violations of the spirit and the letter of the law.

Regulations, to be meaningful, must not just be quantitative but also qualitative. We must be able to enforce the regulation regarding the precise temperature

food is to be served at, but if a resident is forced to eat at five in the morning because that's the only convenient time due to staff scheduling, the regulation really will not do much to enhance the quality of life.

The government should commit itself to introducing new regulations immediately upon the amended act receiving Royal Assent. The message must ring loud and clear across this province that the Ontario government is committed to providing better care for our elderly.

The new regulations will dictate the atmosphere under which residents and workers live. Although tough laws cannot guarantee the existence of love and affection in a specific institution, they should at least be so drafted to ensure residents are no longer treated as simple commodities who exist only as a profit source.

Let us further preface our remarks by stating categorically that no significant changes or improvements can occur simply by amending the existing legislation or drafting new regulations. Sufficient funding must also be made available if residents' needs are to be met and adequate levels of staffing are to be guaranteed.

Staff-to-resident ratios should be measured in direct relation to the amount of time spent with each resident. In many instances, we have found residents received 30 minutes less care than what the present regulations call for. In other cases, we found that when a home's accreditation is due for renewal, it will increase the staff ratio; and after the accreditation is obtained, staff are cut back again. Such cosmetics will not suffice. We will make recommendations later in this presentation as to how to stop this practice. As happens with any standard; the minimum becomes the maximum.

To ensure adequate staff-to-resident ratios are maintained, a nursing home scheduling should be viewed over a six-month or one-year period. If homes fall under the staffing level minimum in this period, the Ministry should prosecute. Staff ratios should always be measured by the amount of time the staff are in direct resident contact.

If the Ontario government is to continue the practice of granting more funds to nursing homes run by municipalities through the Ministry of Community and Social Services, there will always be disparities in the care provided. Simply put, it is easier to provide better care with an extra \$20 to \$30 more per day COMSOC provides each resident.

SEIU is not advocating more money to private sector nursing homes by no means, but the Ministry of Health must ensure specific funding levels are maintained so that a

resident, whether they live in a municipal home or a private nursing home, has available the same quality care.

It is obvious present funding levels have not provided the staff necessary to meet residents' needs. Until the government addresses this problem in a serious way, no amount of tinkering with the language of the Nursing Homes Act will improve the quality of care nursing home residents receive.

We want to now address some concerns and make a few comments on the specific amendments to the Nursing Home Act.

Section 1: Fundamental and Related Principles

SEIU whole-heartedly endorses the principle that a nursing home is primarily the home of its residents, and as such, should reflect the needs of its inhabitants. It's high time that the rights of nursing home residents are acknowledged and enshrined into law. But as commendable as these principles are, they should be restructured into a full-scale bill of rights that will guarantee those rights; and if individuals believe those rights have been violated, they may appeal to the courts.

A bill of rights should also make provision for each resident to have an adequate amount of the time allotted to them in order to meet their physical and mental needs. Regulations are now used to require a minimum amount of nursing and personal-care time. Staffing invariably falls below the minimum hours set. If complaints are made to the Ministry, the Ministry, at best, only issues an order to increase the hours of nursing care. Residents should have the protection of a bill of rights to challenge in the courts nursing homes' level of care.

Principal 9 should be extended to include that residents also have a say in aesthetic qualities of the home, such as what colour the walls will be painted, the type of furniture in the rooms, should there be a piano, et cetera.

To back up the bill of rights, meaningful and tough standards must be established through the new regulations.

Section 4: Ownership and Licensing

While SEIU welcomes provisions in the Act for the Minister to grant or deny a nursing home licence in the public interest, and in so doing take into account the balance between profit and non-profit ownership, we are worried about the definition of "balance."

The present government's intentions may be honorable and may determine a 60 - 40 split to be an adequate balance,

but what about in the future? A future Minister of Health may decide that the public interest is better served if more privately-owned homes exist because his philosophy supports the belief that the private sector can operate nursing homes more efficiently.

The Ontario taxpayer contributes more than a quarter of a billion dollars each year to the nursing home industry. Citizens have a right to know how that money is spent. To ensure the public's interest is maintained, all nursing homes should be under public control.

The Ontario government should put a moratorium on any further licensing of for-profit nursing homes. Instead, the government should commit itself to allocating more resources to charitable and non-profit groups wanting to establish nursing homes.

To ensure no further expansion of the private nursing home industry occurs, Section 4 should be amended to include the concentration of private ownership of nursing homes in Ontario will not be allowed to expand beyond the present levels.

At present, there is no provision in the Act that prohibits a nursing home chain or corporation from obtaining the majority share of all of Ontario's privately-owned nursing homes. This Committee should seriously consider amending the legislation to include an anti-trust provision. The Minister of Health should be empowered under the Act to break up any corporate concentration in the nursing home industry.

Additionally, the legislation should spell out that no foreign corporation be allowed to control or have a share interest in any Ontario nursing home. In November of 1984, Beverly Enterprises of Pasadena, California, bought Bestview Holdings Ltd., the third largest nursing home chain in Ontario. That takeover did not even require the approval of the Minister of Health.

Beverly, the largest nursing home chain in the United States, takes in more than one and-a-half billion U.S. annually, but its record of service to the elderly has been totally deplorable. Beverly, at the time of its Bestview acquisition, was found to be paying less for patient care than the Ministry average in Texas, Florida and California and allocated more of their funds to overhead and profit than the industry as a whole. A Michigan study also showed that the quality of care deteriorated following a nursing home acquisition by Beverly.

SEIU, in conjunction with UFCW, has developed a corporate campaign to organize Beverly employees in the United States. Every organizing drive brought to light the

many problems of care in its nursing homes. No wonder Beverly has taken a totally anti-union position and fights every worker's attempt to organize.

SEIU in Canada was dumbstruck that such a company would be allowed to operate in Ontario and make a profit from Ontario's publicly-funded health care system.

In September of 1986, Beverly sold its Bestview chain to Versa-Care, now making Versa-Care the second largest Ontario nursing home chain.

Beverly apparently believed it could make better profits in the United States. So do some of the biggest nursing home operators in Canada. Diversicare, in January of 1987, paid \$27.5 U.S. for eleven Arkansas nursing homes.

Crownx's Extendicare Health Services Inc. paid \$25 million for seven homes in Washington state and Central Park Lodges paid \$58 million U.S. for eight Florida nursing homes. They are seeking more revenue per bed, but are they really going broke in Ontario? We wonder. After all, the U.S. purchases were made able by the profits generated from Canada's public health care system.

If some companies believe there are better profits to be made south of the border, others believe there can still be profits made in Ontario. Arbor Living Centres, a division of Consumers Gas Co., just a few weeks ago bought two Ontario nursing homes.

Sections: 4(5), (C) and (D).

It is not enough for a person or a corporation operating a nursing home to be honest, competent and able and will not prejudice the welfare of the residents. Further criteria should be added such as a good employee relations record.

Section 4(F): Management Contracts.

SEIU is pleased to find stricter controls applied to contract managers. The legislation should also address the use of health care employment agencies operating in the nursing home industry.

Contracting out in the nursing home industry was nothing but a sham revealing bad management practices. The people who suffered most were the residents who did not receive the continuity of care required because invariably contracted-in employees were not aware of their needs. Contacted employment agencies allow for a rapid staff turn over that is not conducive to a resident's well-being.

In the hospital industry, management contracts have

allowed contract managers to restructure the workforce. We simply ask, when a management contract changes, the incumbent employees' jobs are protected and the new manager is obligated to continue employing the workers at the same wages and benefits.

In other words, the Act must protect against simply changing management in order to reduce wages or reduce staff. It is crucial to the well-being of residents that there be continuity of care.

Section 17: Inspection and Reporting

In order to effectively enforce the Act, the inspection branch and enforcement branch should be constituted as separate entities. If there is a violation of the Act, compliance must be immediate. If it is not, charges should be laid by the enforcement agency.

A Woods-Gordon study showed for a 15-month period 9,802 violations of the regulations, a quarter of them dealing with safety and diets. Inspections tend to deal only with the specific legal limits. It cannot measure the ambience and general day-to-day living conditions staff members or residents are aware of.

To obtain a truer picture of the real conditions in the home, inspectors should have the authority to meet with the residents' councils, advisory committees and staff to hear and substantiate complaints. Inspection reports should be made available to residents' councils and staff.

Residents' councils and staff should have the right to request an inspection at any time, stating the reasons why an inspection is necessary. Inspections should be made at least three times annually, including the annual renewal of licence inspection.

Staffing ratios must always be enforced. There must not be any condition where a nursing home can average out its ratio over a certain period of time. If minimum staffing levels are not maintained, an immediate prosecution should result.

A worse case scenario might take this form. A particular nursing home doesn't meet the required one and-a-half hours extended nursing care. An order is issued, and for awhile the home complies. It then again lapses back and does not meet the required minimum nursing standard. An order is again issued; the home again complies just in time to stave off a possible prosecution.

By such manipulation, the residents and staff are the losers, but the nursing home wins because no fines have been levied and have pockets of money saved for not having to pay

staff. In such cases, SEIU believes the Ministry should withhold in payments to the home any sum of money that equals the wages a home would have had to pay to meet the minimum standard of care hours.

A nursing home operator should have no incentives to achieve any savings or accrue any profits that may be gained through loopholes in the Act.

The mandatory reporting of abuse constitutes a major change to the present legislation. SEIU, although it has never condoned any physical or mental abuse under any circumstances to nursing home residents, we do have concerns that the employees will more likely be charged with abuse than the home's management or administration, because they are in direct resident contact.

The concern really centres around what constitutes harm to a resident. To blame staff for abuse and neglect makes the employees the culprits rather than the home's owners, the home's administrator, or weak government regulations.

If it becomes mandatory to report abuse, there should also be provisions in the Act that allows a care giver to refuse to carry out his supervisor's order if she believes that order will endanger the resident.

In addition, the Act must state that an employee cannot be discharged or disciplined until the due process of law has concluded.

Can the constant serving of cold meals be the fault of dietary employees? Can an employee who must tend to fifty residents alone for a certain time period be charged with neglect because she tells one resident to wait his turn because she is helping someone else? Or is a resident being wakened at 5 a.m. not just as much an abuse as a slap in the face?

The Elm Tree Nursing Home court decision in 1985, I believe makes our point. The court ruled that the province could not hold nursing home licence holders responsible for certain violations including the preparation of food and water temperature for bathing. Instead, the court ruled only staff and administrators could be held responsible. Consequently, the charges brought against the home were dropped.

This case took a long time to reach a conclusion, but while the judicial process continued, the residents and staff still were forced to live and work under intolerable conditions.

The present amendments have not addressed the

question of how the Ministry can hold nursing home licence holders responsible for violations of the Act or its regulations.

Provisions in the Act should allow for prosecution of a licence holder, and if convicted, the maximum penalty should be the forfeiture of the licence.

Even though there should be strict enforcement of the Act, it is also crucial that enforcement be immediate. Lengthy litigation procedures will not serve the interests of the residents. They cannot continue to live under intolerable conditions and possible retaliation while charges are challenged in the courts.

Section 17(c) and 20(4)(b): Financial Statements

One of the most positive aspects of the new amendments are the financial disclosure provisions, but a simple profit and loss statement will not give the true financial picture of a particular nursing home. We would encourage this Committee to amend Section 20(4)(b) so all financial statements will include the following:

1. A statement of all income from private and public sources.
2. A statement of all wages and benefits paid.
3. A complete list of expenditures that must include an itemized list for food, utilities, furniture, recreation, mortgage payments, taxes and management fees.

Management fees paid to a family member of an owner under present legislation hides the true profit of the nursing home. For example, Heritage Nursing Home in Toronto claimed a net profit in 1980 of \$118,193. But this figure underestimates the real profit because an expense of \$158,278 was given to the wife of the owner as a management fee.

Management firms, when they are contracted by an owner, should also have to file financial statements with the Ministry for any other corporations the management firm or its principals have a share in.

Section 17(d), and 17(e): The Residents' Councils

Other groups who have appeared before this Committee have already stated that if there was a really good inspection system, there would be no need for residents' councils. SEIU concurs. But we also believe that senior citizens and all residents of nursing homes should be entitled to an advocacy system that will enable nursing home residents to express their needs and develop ways and means to satisfy those needs.

Section 17(d) should be amended to allow nursing home staff to be members of a residents' council as long as they are not related to the home's owner, management contractor or administrator and do not own any voting shares in the nursing home or the management company operating the home that may present a potential conflict of interest.

No one understands better the conditions and environment of a nursing home than its staff. Staff should be able to speak out for all residents' interests.

We do not believe though that a residents' council should become the first line of defence against investigating and remedying complaints. This is what 17(e) and 2(e) appears to imply. Residents' council advisory committees are asked to mediate and resolve any dispute between a resident and the licensee. Does this mean the Ministry will not act until all avenues available to resolve the dispute are closed, and will this not impede the resolution of a dispute if the licensee continues to violate the Act until Ministry of Health officials step in?

A residents' council and advisory group should more properly advise and report to the Ministry any violations of the Act. The onus should remain with the Ministry to investigate, inspect, and file charges.

The reason we are concerned about increasing the responsibilities of residents' councils advisory groups is simple. Will enough people be willing to serve on a residents' advisory council within a particular community, and will they have enough expertise and willpower to act as competent agents for the residents? What mechanisms are in place to ensure the Ministry that residents' councils are functioning properly?

The Act should allow the residents of a particular home to veto as to whom may serve on a residents' advisory council.

Section 19(a): Penalties.

SEIU believes the fine structure ranging from 250 to \$5,000 for a first offence is too lenient. From November, 1984, to January of 1986, according to the Toronto Star, 10,000 violations of the Act occurred. There were only seven convictions and a total of \$1,707.50. in fines.

For certain offences, such as not meeting minimum staffing requirements, a home, upon conviction, should be fined the amount of money the licensee saved by not meeting the staffing regulations. We also support penalties that would, for a period of time, put a hold on admissions and the number of beds.

I respectfully thank you for listening.

Mr. Chairman: Thank you, Mr. Roscoe. Are there questions from the members the Committee? Mr. Jackson.

Mr. Jackson: Thank you, Mr. Roscoe. Maybe I could work backwards from some of the points that you raised. Your very last statement: "We also support penalties that would for a period of time put a hold on admissions and numbers of beds."

What do you actually mean by that? These are not new bed allocations; these are when a bed comes free, they wouldn't get an admission until such time as the matter was corrected?

Mr. Roscoe: Yes.

Mr. Jackson: Even with a waiting list?

Mr. Roscoe: Pardon?

Mr. Jackson: Even with a waiting list?

Mr. Roscoe: Even with a waiting list. What you're doing is there's a violation in the home and you're condoning it. You're going to put new people in. We just feel that would be wrong. We feel that it would speed up and the correct the situation if that kind of a penalty was imposed.

Mr. Jackson: On the residents' councils, you talk about all residents of nursing homes would be entitled to an advocacy system. I think this Bill primarily addresses the privately-owned nursing homes. Don't you advocate this system for all--

Mr. Roscoe: Yes.

Mr. Jackson: -- all types of nursing facilities?

Mr. Roscoe: Yes.

Mr. Jackson: Profit and non-profit?

Mr. Roscoe: Yes.

Mr. Jackson: And --

Mr. Roscoe: I can't really see any difference for those purposes.

Mr. Jackson: I thought that was the way I was interpreting your statement, but I wanted that clarified

that you include all.

On page 8, you refer to if it becomes mandatory to report abuse, there should also be a provision in the Act that allows a caregiver to refuse to carry out a supervisor's if she believes that order will endanger the resident. Have you got a couple of examples that might bring that point a little more clearer to me?

Mr. Roscoe: Right off the top, I would not give it to you. I'd be glad to send it to you - a couple of examples - if you want.

Mr. Jackson: That would be helpful to me. I'm trying to place it in the context of this Bill and your union and its implications.

That's all the questions I have at the moment, Mr. Chairman.

Mr. Chairman: Mr. Andrewes.

Mr. Andrewes: Mr. Roscoe, I go to the end of your presentation. Thank you very much for your presentation.

I want to start by agreeing with you in your statement relative to the residents' councils; in particular, the residents' council advisory committee, which I think flows from that discussion. Do you not believe though that the residents' council should become the first line of defence against investigating and remedying complaints? It appears that there's some degree of unanimity in this, or you may get some degree of unanimity from this Committee on that point of view.

The paragraph that just precedes that. No one understands where you've made the suggestion that the members of the staff in nursing homes should be appointed to the residents' council.

I'm not sure that this particular amendment doesn't allow for that, given the fact that the Minister has discretion to appoint three people to the residents' council advisory committee. Does that recommendation -- would you like to see, or would you like to see it more specific in the Act in terms of the makeup of the residents' council or the residents' council advisory committee?

Mr. Roscoe: I think we would like to see it more specific, that there are people like that included on the committee.

Mr. Andrewes: If you go to page 6 of your presentation at the bottom where you talk about management contracting out, in the final paragraph you say that people

who suffered most were the residents who did not receive the continuity of care required because, invariably, contracted-in employees were not aware of their needs. Is that a general statement? Would you stand by that statement regardless of the service provided?

Mr. Roscoe: Yes. It's simply the fact that through the -- that the people who work constantly in a nursing home become very personal with the people that they're looking after, and they know their needs. When you keep changing those people around, that same kind of thing does not go on. And if you contract it out, invariably the contractor is paying less. When they pay less, the staff turns over, and so you don't have that continuity of staff-to-patient care going on.

Mr. Andrewes: But I think you'd have to agree there are certain services where the staff person performing them does not come into direct contact with the residents.

Mr. Roscoe: Well, as we've pointed out to you, when we did take on that fight with the nursing home, it was the core jobs which was the direct nursing care and everything that was the thing, the case in point. It was the nursing aides who have the direct care to the patients.

Mr. Andrewes: When you're talking about contracting out, you're speaking more specifically of the hands-on services to the resident?

Mr. Roscoe: Well, there is not very many places in a nursing home that there isn't direct relationship between the patients and the staff. You take the dietary. Other than the people who may be actually doing the cooking - the dietary aids - they serve the meals, they even feed the patients at times if that's necessary.

And the laundry is the same thing. There may be one or two people in the nursing home that may not come into as much contact with the inhabitants of the home -- the collecting of the laundry and everything else. It's all direct. It's not like you've got a small group up here, that they're the only people who see the residents in the home; that isn't the way it's operated. There's a complete intermingling of staff and the residents.

Mr. Andrewes: When you took on the issue of contracting out and you were successful in terms of - what did you call them? - the "core programs"?

Mr. Roscoe: That was the core jobs which is basically right.

Mr. Andrewes: Did you challenge the other services?

Mr. Roscoe: We didn't lose any more.

Mr. Andrewes: That was the only area in which the contract --

Mr. Roscoe: Well, we challenged it. They were just laying people off all over and contracting out all of the jobs, but that one specifically practically stopped it because they didn't challenge it. The challenge was on whether there was the direct patient-staff relationship there looking after them. We didn't get challenged on that. If you're asking me could they contract out the dietary people, I'm sure we would have come up with the same kind of argument as we did with the rest of them.

Mr. Andrewes: So, in effect, the contracting out stopped when you won your challenge?

Mr. Roscoe: It has basically stopped, yes -- picketing a few homes and things like that.

Mr. Chairman: I remember it well.

Mr. Andrewes: On page 5, you talk about the government should put a moratorium on any further licensing for-profit nursing homes. Instead, the government should commit itself to allocating more resources to charitable and non-profit groups wanting to establish nursing homes. Could you define what you mean by "resources"?

Mr. Roscoe: Money.

Mr. Andrewes: In what way?

Mr. Roscoe: Well, it's my understanding that on a non-profit home or a charitable home, that the charity has to put in a lot of the money, and they get little funding from the government. In other words, it's not totally funded like it is in a profit-making situation.

We were just in negotiations the other day with a nursing home, and it surprised me to find out that they had to supply most of the money whichever way they could get it, and they were not totally funded like the rest of the nursing homes. They were a charitable home, which I would have thought would have been the other way around.

Mr. Andrewes: In what respect is it different?

Mr. Roscoe: Is what different?

Mr. Andrewes: I'm thinking of the current process that's in place where there's a tendering process for nursing home beds, which the successful tenderer submitted, then commits themselves to make capital investments and for

that capital investment and the provision services receives compensation that's roughly \$29 a day. Is that different from the non-profit charitable sector than it is for the for-profit sector?

Mr. Roscoe: Well, the charitable homes have to find the funding to put up the capital structure to start with.

Mr. Andrewes: And who finds the funding for the private sector?

Mr. Roscoe: Well, the private sector finds the funding as well, but they get more money from the government than the charitable --

Mr. Andrewes: Well, I think somehow its just the reverse. The non-profit, particularly the homes for the aged sector, get more --

Mr. Roscoe: I'm not talking about homes for the aged. I'm talking about the nursing homes. The homes for the aged - if I may - the homes for the aged are funded under COMSOC.

Mr. Andrewes: That's right.

Mr. Roscoe: All right. And COMSOC puts an awful lot more money into that section than the Ministry of Health does into the nursing homes. They put in \$20 to \$30 a day more.

Mr. Andrewes: Yes, into the per diem.

Mr. Roscoe: That's right. And if you've got \$20 or \$30 a day more to work on to provide the needs for the person in the home, I tell you that's quite a difference.

Mr. Andrewes: But, I think I recall you just said that the non-profit sector - the for-profit sector - received more compensation than the --

Mr. Roscoe: All right. Then we're talking about two different things here, and there's three different sections. Let me straighten that one out.

In the homes for the aged which are generally run by municipalities in conjunction with the government, they're funded under COMSOC. The nursing homes profit section are funded by the Ministry of Health, but then there is also within that framework charitable homes. So we have three different identities there, and we're trying to mix apples and oranges.

Mr. Andrewes: Let me be clear then. What funding does the for-profit sector under the Ministry of Health get

that the non-profit under the Ministry of Health don't get?

Mr. Roscoe: It's my belief that they get about \$49 a day per patient. The charitable homes have to find most of that money. They do not get \$49 per day.

Mr. Cooke: They get identical amounts.

Mr. Roscoe: Well, that's not my information. I thought it was up until a week or so ago, too.

Mr. Andrewes: They get \$29, I believe, from the Ministry of Health. The balance is paid by the residents from their pensions if they don't have any other source of income.

Mr. Roscoe: Well, If I'm wrong, I --

Mr. Cooke: But you're talking about rest homes, and there are some non-profit seniors' homes that would get no capital funding and no per diem funding either.

Mr. Chairman: Mr. VanBeek.

Mr. VanBeek: We're referring to a specific case and I think Mr. Roscoe knows. But I think Mr. Andrewes' point is that a charitable home, whenever it's in deficit - has a difficult situation or whatever - has to go through a long process to try and get any money whatsoever out of any government source, mainly COMSOC.

Mr. Andrewes: Yes.

Mr. VanBeek: Correct?

Mr. Andrewes: Yes.

Mr. VanBeek: Here these people are providing a service. They put up the capital funding; they're providing a service for a particular community - which may be an ethnic community, it may be a religious community; whatever - are providing a service and are getting all kinds of hassles in terms of trying to receive adequate funding from government sources to run that home.

The private care institutions know the bottom line. If they don't get the funding, the services are cut back. The residents suffer; the staff suffer, because the bottom line is profit.

In the charitable homes, the bottom line is resident.

If you're not going to provide the funding, you're not going to have the staffing levels to provide the care that's necessary. It's as simple as that. And this Bill doesn't speak to the funding or the staffing levels, and I think this Committee should seriously look at those inadequacies of the Bill.

Mr. Andrewes: Have you anything that you can give us that would substantiate your statement, your generalized statement, that the level of care in non-profit nursing homes is better than it is in profit nursing homes?

Mr. VanBeek: We can give you chapter and verse. I don't like to necessarily just point out specific ones here, but there's one we're negotiating with right now, Carefree Lodge Seventh Day Adventists, I believe. When that institution -- Certainly we have taken a look at their operating expenses and I don't see any reason why they should lie to us.

We have looked at certain facilities in terms of the Orange Lodge that is under contract to us. United Church Lodge's Albright Manor in Grimsby, I believe in your own riding, sir.

Those are specific examples of charitable homes trying to provide a service, and at the same time, being aware that staff needs also have to be met. If you're not going to be able to get the funding, then you're not going to get adequate standards of staff either and continuity of staff, if I may, so that you have a permanency there that enables the care of the resident to be met because you don't have the turnover and staff know what patients' problems and concerns and all that sort of thing have.

Mr. McLean: I have a supplementary, Mr. Chairman, on the first point that Mr. Andrewes raised.

Mr. Roscoe, with regard to the third paragraph on page 5 where you indicated that the system levels should be maintained and no further approvals be given, I believe the Ministry of Health have indicated over the next several years they wanted to increase by about 600 the nursing home beds across the province. There's been several given out already. But you're indicating that there should not be any more given out; is that correct?

Mr. Roscoe: That's right, to the private sector.

Mr. McLean: In Ontario, there's a great number of senior citizens in great need of nursing home beds. We have approximately, I know, in the hospital in the area that there are 34 people, approximately, in the hospitals that should be in nursing homes. It would be a great saving to

the province, the Ontario Ministry of Health, to give them food.

I fail to see why you would think that the lack of nursing home beds that's been discussed should not be given out to nursing home operators regardless of whether they're private or public, in order for those people to be in a more homey atmosphere. I think it would be better for those people --

Mr. Chairman: We've having trouble getting you on the mike.

Mr. McLean: So I fail to see why you want to put a freeze on them, when these people would get better care in a nursing home.

Mr. Roscoe: I'm not saying you should put a freeze on the building of nursing homes. I think that that should be expanded and I think more homes should be built. I just don't think they should be under the nursing home operators.

When you can take the millions of dollars, take the millions of dollars out of the health care system that the taxpayer pays for and then go and expand your operation in the United States, I think that those millions of dollars could be better used in Ontario to build nursing home facilities, and you won't have those people in those hospitals.

Mr. McLean: You indicated there was 333 nursing homes in Ontario?

Mr. Roscoe: To the best of my knowledge. It may have gone up in the meantime.

Mr. McLean: Are those all private, or how many of those would be --

Mr. Roscoe: 290 some-odd are private.

Mr. McLean: And there's only a very few that's public, then?

Mr. Roscoe: That's right.

Mr. McLean: You would agree then that the public ones, it would be great to have them expanded then?

Mr. Roscoe: Yes.

Mr. McLean: Thank you.

Mr. Chairman: Mr. Cooke.

Mr. Cooke: Thank you, Mr. Chairman. I might just mention one of the documents that perhaps the Committee should have filed, is the Dorothy Crittenden report which is -- I don't think whether the member who just spoke has read the report, but Dorothy Crittenden, not known to be a radical, suggested very clearly in her report that there was a significant difference between the profit and the not-for-profit sector, and that the not-for-profit sector was providing better care. So you might want to read that report.

Mr. Chairman: I'll see if I can get copies from the Ministry. I'd like to see it.

Mr. Cooke: Thank you. I'd like to get an idea from you as to what is happening in terms of trends towards part-time workers in the nursing home sector as well.

Certainly one of the complaints that I get in addition to contracting out is a problem with staff turnover and a conversion to part-time workers, which affects the staff but also very much, in my view, negatively affects the residents when from one day to the another they don't know who is going to be taking care of them when they wake up in the morning. It contributes to disorientation and difficulties with creating a home atmosphere. Have you seen a significant increase in the use of part-time workers, both in the homes you represent and perhaps in homes you may not represent?

Mr. Roscoe: Well, that is definitely what is happening. They have gone from full-time workers into part time and it just increases on a daily basis. I think that what causes a lot of the problem, where we generally had talked about part-time workers being less an 24 hours per week, we have found that the full-time people have been cut back to anywhere between 24 and 37 and-a-half hours. And it has become more the norm that people are working less than 37 and-a-half hours a week possibly in shifts of 25 and 30 hours a week.

And I would term that "part-time work" because what they're doing is they're just bringing more people in and working them less hours in a period, and it is becoming a part-time industry. And it just increases every day.

Mr. Cooke: What has your experience been with staff turnover as the patient load gets heavier and as there's more conversion to part time and other difficulties that exist? Are you seeing a higher turnover of staff?

Mr. Roscoe: Strangely enough, I would like to be able to say, "Yes, I'm seeing that." But I'm not really seeing that. There is a normal staff turnover in the nursing home. But what is happening is that they have a list of employees

that is about three times what they need simply because they've got them on 20-, 25-, 30-hour shifts, and they've got a list of people that they just keep calling in.

There's a staff turnover when it comes to that. But they don't have-- If they're working people 37 and-a-half hours a week on regular shifts, it would be much better for one, the employee. It will also be better for the residents, because they're seeing two and three people during the day that they didn't before.

Mr. Cooke: When inspectors come out to the homes, I know I've had the experience of trying to convince the inspectors to meet formally with staff - either with the representatives, with individual staff or both - and have always been given the explanation that the inspectors don't recognize a union. Therefore they don't meet with a union if the staff are lucky enough to be represented by one. That's my experience in southwestern Ontario, and I'm wondering whether that's your experience elsewhere?

Mr. Roscoe: To the best of my knowledge I have never known an inspector to contact anybody in the home that may be connected with the union, if that answers your question.

Mr. Cooke: I'd like to just make reference to your comment at the beginning of page 4 about the bill of rights or it's improperly, in my view, called a bill of rights; it's a statement of fundamental principles.

And I tell you that we're working on an amendment that would maintain a statement of fundamental principles for interpretation of the Act, which I think is important, but also a bill of rights and making sure that it is in a written contract between the residents and the nursing home. And we're also trying to draft an amendment which is the best attempt that I can think of to deal with staffing that will say that the nursing home has to be staffed in a manner as to meet the requirements as set out under the bill of rights.

As you'll recognize there's no section of the actual Act that deals with staffing that's in the regulations, and we're restricted as to what we can amend by what sections of the Act are opened up to us by the Bill.

So, so far, that's the only way that I can see the Committee trying to address the staffing problem, even though it will probably be in a weak way, but nonetheless would be the best that I can see unless the government is willing to bring in an amendment to the Bill to actually strengthen the staffing regulations that currently exist.

Mr. Roscoe: I'm the sure the Committee will find a way to address it.

Mr. Cooke: We also were looking at an amendment that I would like your reaction on, and that is when a nursing home licence is being issued, or when its up for the annual review or when there's a transfer of ownership and therefore a new owner is going to receive that licence, of opening up the process and having a public hearing or a public meeting or whatever, that gives the opportunity for the community, the residents, the relatives of the residents and the staff the opportunity to give written or oral submissions to the director, who will ultimately make the decision of the issuance of the licence. We're looking at an amendment that will provide that automatically when there is a new licence being issued or perhaps on a rotating basis of every three years when it's the automatic renewal of the licence.

Mr. Roscoe: I certainly wouldn't be opposed to that, and I reason I - and I mentioned it in my comments in the brief - I think that if our organization had had an opportunity to put forth their comments when Beverly took over Bestview, I'm sure that somebody would have looked at that a little bit differently.

Mr. Cooke: We can't count on it, but we can hope.

Mr. Roscoe: Well, I'm sure there would because the evidence that we could put before any kind of committee as to how that company operated in the United States would have been massive, and we do have massive information on that particular company.

Mr. McLean: Have you any idea -- that was turned over very quickly, within a year, wasn't it, from Beverly to --

Mr. Roscoe: I think it was about two years.

Mr. Cooke: Yes, it was longer than a year.

Mr. Roscoe: Yes, it was more --

Mr. McLean: Does anybody have any idea what profit was made on that?

Mr. Roscoe: No. I tried to find out.

Mr. Cooke: You can't find out under the current regulations because there's no way of getting access to the information.

I have some concerns --

Mr. Roscoe: If I might, I think they just wanted to get out because they found that they couldn't use the same kind of practices in Ontario that they could in the United States.

Mr. Cooke: It would be interesting to see, though, how much the individual beds, the value of the licence had increased in the two years that they owned it. They probably made a fair amount of capital gains on it.

I share some of your concerns with regard to the residents' councils and the residents' councils advisory committee and the residents' council adviser. I just have one concern about your suggestion and the suggestion that perhaps staff should be able to be on the residents' council.

While I understand your point of view, do you not see that there could potentially be a conflict of interest, that there could be direct influence and perhaps, on occasion, items come to the residents' council that involve staff that may not be complimentary towards staff, and that if staff were there as part of the council, it would be difficult for them to deal with it?

Mr. Roscoe: I suppose if you take it to the n'th degree that's possible. But I guess what we're mostly concerned about is that the staff is consulted, because they are the people, generally, who are with these people every day.

It may be hard to comprehend for some people, but people working in nursing homes, it's not like going operating into a steel plant and operating on a production line all day. These people become part of the family of those people in there in a lot of cases, and they become very very close.

Yes, you will find, I suppose, where there could be problems if the staff were on the advisory council and there's somebody complaining about the staff member. I suppose you'll get that anywhere. Nothing is going to be a hundred per cent. And I suppose if you take it that far, you're quite correct. But I still think that the staff should be consulted by whomever to get the --

Mr. Cooke: We'll be looking at some amendments to, I think, more closely define what the residents' council role is.

I don't want to see the residents' council given the power to investigate complaints. I have just this strong suspicion that what will happen is that when questions are raised about the quality of care in a particular nursing home, and if by some chance the residents' council, which I think they are vulnerable to being co-opted - and I'm not suggesting that all residents' councils would be but I think that's a possibility when they reside right in the home - that we could run into a problem of residents' councils

being used to justify the decisions of an inspection branch or lack of action on the inspection branch, and they be used as a buffer rather than being used to properly define and advocate for some amenities in the nursing homes for the residents.

So, I think we're going to look at some amendments to more closely define what the role really is and to make it clear that it's not their role to enforce the Nursing Home Act.

Mr. Roscoe: Right. Well, that might be an advantage of having staff on the advisory council. That couldn't be co-opted quite so easily.

Mr. Cooke: Thank's very much.

Mr. Chairman: Thank you, Mr. Cooke. Mr. Callahan.

Mr. Callahan: Just a few brief questions, if I could. Of the 333 nursing homes in Ontario, you've indicated 299 are operated as profit-making institutions. How many of those are unionized?

Mr. Roscoe: About 50 per cent of them are unionized and that would take in about 75 per cent of the beds in Ontario.

Mr. Cooke: And the difference of the 34, if my math is right, 34 not-for-profit nursing homes, how many of those are unionized?

Mr. Roscoe: I really couldn't give you that figure.

Mr. Callahan: Well, can you tell me, is it 50 per cent?

Mr. Roscoe: I really don't know that figure. If I knew it, I would tell you.

Mr. Callahan: Well, do you represent -- does your union represent any of the workers in those --

Mr. Roscoe: Yes. Well, VanBeek just referred to the one down in Beamsville, and the Trillium Home for the Aged up in Orillia; Carefree Lodge was just organized a year or so ago. Those are three that come to mind.

Mr. VanBeek: And you have about 67 homes that are non-profitable that come under the Ministry of Health included in those 34 homes that you're referring to that are funded by the Ministry of Health rather than COMSOC.

Mr. Callahan: Well, what I'm trying to get at is if you represent some of these, why can't you tell us the

numbers of the not-for-profit that you represent?

Mr. Roscoe: I've just never looked up the figures. I assure you --

Mr. Chairman: There are are more unions than the SEIU involved.

Mr. Roscoe: There's at least five major unions in the nursing home field. But I can find out the figure. If you're that interested, I'll --

Mr. Callahan: Well, yes; I would like to know, because it seems to me that -- Are you able to secure -- and just generally able to secure -- better contracts for the workers that you represent in the for-profit section or for the not-for-profit sector?

Mr. Roscoe: No. I don't think there's any difference in either one of them.

Mr. Callahan: I'm not sure how you're answering my question. Do you wind up with the same benefits for the workers in the not-for-profit as you do for those in the profit sector?

Mr. Roscoe: You're going to find that there's a few disparities one way or the other, but they're generally the same. They would be comparable depending on how long they've been organized.

Mr. Callahan: So the wages are relatively the same?

Mr. Roscoe: The wages would be relatively the same, in the large chains, if I can say. Take Extendicare and Diversicare, and a number of them where we carry on central negotiations with those particular people. They're more or less known as the flagship and the other ones try to meet that particular contract.

Mr. Callahan: We'll then, I'm trying to get a handle on this because I've read or heard somewhere that the employees in the not-for-profit -- the employees in the not-for-profit make better wages than those in for-profit.

Mr. Cooke: I think probably you're referring to homes for the aged.

Mr. Roscoe: You're talking about homes for aged. I can give you the John Noble home in Brantford, for instance. It is funded through COMSOC and the municipality in Brantford; their wages would be very comparable to the hospital workers.

Mr. Callahan: So this problem does not exist in the

nursing homes field?

Mr. Roscoe: No, they get less than the hospital. They would get less than those two that we're talking about.

Mr. Callahan: Okay, but there's not a disparity between the profit--

Mr. Roscoe: --the profit and non-profit? Not that I would make an argument with you at this particular level.

Mr. Chairman: -- that homes for the aged get a higher per diem from the government than do nursing homes?

Mr. Cooke: And the Nursing Home Association says that's one of their problems why the care can't be as adequate. To the point, one of the contributing factors is that the homes for the aged pay their employees a higher rate, so that it doesn't necessarily go into larger -- You can't make the comparison between nursing homes and homes for the aged.

Staff in homes for the aged get paid much more decent wages than those people in the nursing homes, and that's the point we've made in your other Committee. Mr. Chairman, the other Committee, you probably should get to know the difference between homes for the aged and nursing homes before we get that Committee cranked up.

Mr. Chairman: Thank you very much, Mr. Cooke. You're most helpful.

Mr. Callahan: Just to go back, your argument is that the care in the for-profit is less meritorious than it is in the not-for-profit because of the profit motive; that's basically your argument?

Mr. Roscoe: Because the dollar becomes the bottom line rather than the care.

There is no motive for a charitable or non-profit organization other than good management, I suppose, to try and collect money rather than turn it back into the home, where there is a definite motive for a profit-making organization to save as much money on the operation as they can, because more goes to the shareholders and more goes into the pockets of the corporation.

Mr. Callahan: That may well be, but in addition to that, one would expect that where your for-profit would have to compete with some 298 other for-profit nursing homes, you have to provide equal if not better service than they do if you're going to get the residents into your nursing homes.

Mr. Roscoe: Not really, sir. Because, you know, it was mentioned over here, there's a waiting list. The nursing homes are full.

Mr. Cooke: You can't go shop around.

Mr. Roscoe: There's no place to go. You go on a list and they put you into a particular nursing home.

Mr. Callahan: You're saying that demand exceeds the supply, basically, and that's the reason why there is almost a captive market?

Mr. Roscoe: There sure is.

Mr. VanBeek: I don't know if you read the press on the weekend, but Country Place Manor just closed - that was a for-profit. The Ministry closed the home and took away the licence. It had been in a terrible state of disrepair and terrible resident care for quite a while before the Ministry finally did take over the home.

They're competing with the other 299. If you had been around four or five years ago when contracting out was an issue, and we were at this Legislature quite a number of times talking about contracting out, they were competing with other homes, but the level of care in every instance went down the tubes as opposed to the profit motive.

Mr. Roscoe: Just the fact that there isn't enough nursing homes to take care of the people who need nursing home beds. Those people, as it was indicated by the gentleman on my right, said that these people are now being housed in hospitals, and they're waiting for openings. There's waiting lists pretty near in every community.

And I guess my part, if I may deviate from everything that I've said, the part that bothers me about that is that when I look at those big nursing home chains and I see literally millions of dollars going down to the United States to buy acquisitions down there, that's millions of dollars of Ontario taxpayers' money that could be building nursing homes to house those very people that can't get a place to live.

Mr. Callahan: But surely if I - and this is my last point - but surely if the real or one of the issues is the question of the lack of availability of either for-profit or not-for-profit homes is the problem, how do you -- are you proposing that the government should create more not-for-profit homes to meet that gap?

Mr. Roscoe: Yes. That's precisely what we're saying.

Mr. Callahan: So you're not suggesting that there

should be some mechanisms to force the for-profit groups to take the profits that you say they're channeling off into the United States and build more for-profit homes here?

Mr. Roscoe: Well, that would be an ideal situation if you could do it. I just don't know how you would do that. They claim that they're broke now.

If you sat in negotiations with those employers as often as I sat in there and heard them tell me how broke they are and how rotten the government is in giving them money. And I said, "Well, you know, the government or the employers, show me the money." I've got people on government that think I'm on the employers' side, because I'm saying he's not giving them enough money.

If I say that to the government long enough, maybe they will get into it and find out if they have got enough money. But it's obvious that deep down inside I know they got the money - \$58 million worth - to go and buy some more. That \$58 million could put up an awful lot of nursing homes in this province and relieve the backlog of people waiting to get into nursing homes.

Mr. Chairman: Thank you, Mr. Callahan and Mr. Roscoe and Mr. VanBeek. Thank you for coming. It's been a while; I'd forgotten about -- It's been so long now since the -- The Don Mills Foundation, I guess, was the first contracting out, and the Kennedy Road Lodge and others that the workers and reps that I worked with back in those days to stop the contracting out. I'm pleased to hear that it doesn't seem to be as severe a problem now because of those victories. Are there still cases of contracting out to --

Mr. Roscoe: Now, it's a little bit more subtle. They have the agencies out there. Rather than replace the worker, they bring the agency who are brought in - the agency people are brought in - for when people are off sick or some such thing. I'm not just sure how that balances, but I'm sure that once we get it all figured out, we'll be coming again.

Mr. Chairman: Well, I look forward to seeing you and for being here this afternoon.

Mr. Roscoe: Thank you.

Mr. Chairman: Our second deputants this afternoon are the Ontario Coalition of Senior Citizens Organizations, Mr. Sugarbroad, Ms. Woodsworth and Ms. Purdy. Yes, please, take a seat in front of me. If you can stand it for any length of time. You can always look down or look away. It's not necessary to look at one chairman for protracted periods.

Well, we've seen some of you before, already.

Welcome. We have your proposal distributed. You can take us through it any way you would like.

Mr. Sugarbroad: Just like to introduce--

Mr. Chairman: Please, you are going to have to stay seated so we can pick you up on the microphones. The microphone is directly in front of you.

Mr. Sugarbroad: I see.

Mr. Chairman: If you could introduce your colleagues to us, and then take us any way you want through your presentation. Then we'll open it up for questions following that.

Mr. Sugarbroad: My name is Stan Sugarbroad. I am the President of the organization. I would like to introduce Sheila Purdy who is an associate member of our organization through the fact that she is from the Advocacy Centre for the Elderly, who are affiliated to us, and Jean Woodsworth from the Ontario Division of Concerned Pensioners, pensioners concerned, and Jenny Gilbert behind us, who is the co-ordinator of that organization.

Sorry if I'm a bit hesitant because names don't come easily to me.

Mr. Chairman: I have got the same problem, but I have got your names written down so I will be all right.

Mr. Sugarbroad: Sheila Purdy will be presenting the brief on our behalf.

Ms. Purdy: I just want to thank you for allowing the Coalition to present a brief today. And I might just mention, I'm a fairly new member to the Coalition, and the Advocacy Centre for the Elderly acts in an advisory capacity only to the Coalition. But I understand that the Coalition now represents at least 250,000 individuals through their different organizations, and it is growing every day. The Coalition came together primarily through the de-indexing concerns a few years ago - the pensions being de-indexed - and from that rallying point have continued as a strong voice.

We have looked at the Nursing Home Amendment Act and have put together the brief which you have. The Amendment Act covers a lot of ground, and we don't intend to go into detail in all the areas. The most important areas, from our point of view that we want to address, are the residents' fundamental principles, as they are called, and the councils, the residents' council, and the advisory committees. I'll touch on other areas as well, and Stan and Jean will help me with the questions.

It is the Coalition's position that the fundamental principles as they are contained in S(1)(a), and the sections that I refer to are what they will be in the new Act if they are adopted.

Our belief is that the principles themselves as they stand now are a tremendously valuable educational tool in that one of problems with, as we see it with nursing home residents and their families, is that they have never had a forum for discussing their rights -- what they should be entitled to in a nursing home. And the fundamental principles, as such, allow that kind of discussion to take place. We wouldn't want to see them thrown out, because it's difficult to put them in the Act in a different way. In other words, we are going to propose that they be beefed up to a bill of rights.

But in the absence of that, we wouldn't like to see them thrown away. We think they serve a valuable tool. They are a valuable tool, and they will serve a purpose.

We have people in our organization who go into nursing homes, and in their experience - and I'm taking it from their opinion - that the fundamental principles will allow them to talk to nursing home owners and try and deal with some problems.

But back to our point, which is that the fundamental principles must be beefed up to a bill of rights. We believe that the way to do that is to take what you have in the Amendment Act now, look at the ones that are clearly unenforceable, and put them into a preamble. In other words, as we put on page 2, 3 and 4, you would take the principle that the nursing home is primarily the home of its residents and, whereas each resident is entitled to be treated with dignity, courtesy, and respect, you might add: Whereas the residents are to be given the opportunity to form friendships and enjoy relationships, and to contribute in accordance with their ability to physical, psychological, social, cultural and spiritual needs of others. They would form a preamble.

Following the preamble would be substantive rights of residents. The bill of rights would guarantee the rights set out in them, subject only to the rights of other persons in the nursing home. And therein would follow a list of rights.

We have chosen to stay with the Amendment Act numbering and have elaborated on some of the rights and then afterwards have added to them. In other words, we have taken No. 2, which is the right to shelter, food, and clothing, and we have added personal care, nursing care, et cetera.

We look at No. 4, for example, and we have embellished that quite considerably. We have looked at the fact that a resident should be able to participate in the planning of his or her own treatment; the right to inspect and obtain a copy of medical records which, I believe, is not the case now - there are certain people who have rights to those records, but it is not the resident; the right to information about his or her medical condition and prospects for recovery; the right to know about proposed treatment and alternatives; and the right to refuse treatment and medication to the extent provided by law, and to be informed of all possible consequences of refusal.

We believe that when you deal with the rights to treatment, you've got to put in a provision for substitute consent in the case of a person who does not have the mental competence to give informed consent.

On page 4 of our brief, in our commentary to No. 4 of the Rights, we draw the analogy with the Mental Health Act as an example - not necessarily a perfect one - where psychiatric treatment is proposed for a patient who is not mentally competent. And in that case, the consent of the nearest relative is required. And the person who is not mentally competent may apply under the Bill 7, numbering 35 S.S. 2(a), 2(b) and 2(c) of the Mental Health Act, that any person may apply to the Review Board to enquire into whether he or she is not mentally competent. And then the treatment is stayed pending a final decision of the Review Board. If you are going to look at the giving or refusing of medical treatment, you must look at the competency issue.

When we looked at No. 5 of the Fundamental Principles, we divided them into -- actually 5 and 5(a) just to keep the numbering simple. The problems of admission to a nursing home are quite different from the problems of transfer and discharge. Often a person being admitted to a nursing home is coming out of a hospital; the hospital can no longer care for that person. There is a concerted effort by the Discharge Planning Committee to get any place for that person to to be admitted into a nursing home.

And again, the question of consent comes up. The question that you would look at is the role that nursing homes have in accepting residents, and whether they are aware of residents being admitted who are not giving their consent to going into that nursing home. We see the problems every day and the referrals to our office of people who are being transferred from hospitals into nursing homes have very little knowledge of what is happening. Their families don't know. They feel that they are not in control of the situation and are not able to give their consent.

When you look at transfer and discharge, there must be a much better and fuller method of discharging a patient

other than saying, "You are not suitable for this place; we want you to move elsewhere," and giving them a week's notice or, in some cases, 48-hours' notice. What we haven't actually put into our revised right but should go in there is a "right of review": Should the nursing home alone be allowed to decide whether a person is kicked out? The nursing home is the home of that individual and, as such, we believe that there is a case for review should that person not want to move.

Under your No. 6, we put in more elements of privacy, recognizing that a resident sometimes does not feel that he or she has the privacy in dealing with doctors or lawyers or visitors. And we want that embellished in the way that we proposed.

Your Amendment Act looks at the right - or the opportunity, I mean - for a resident to enjoy relationships. That immediately raises the question of whether residents of nursing homes have a right to have private space with his or her spouse; the opportunity for a non-resident spouse to spend the night with that person. What provisions are available now? They are not very satisfactory in most nursing homes. But it is something that if we are to ensure the dignity of nursing home residents and their privacy and their right to continue living as we would like to think we are living, or how we would like to live when we become nursing home residents, if that should be the case, then we have to look at privacy with the non-resident spouse: the right for married spouses to share a room, unless it would be medically contra-indicated; the right to participate in a residents' council is a clear one and ought to be there, and we agree with that. And what we have done with the rights to form or the opportunity to form friendships is to put that in the preamble which we have done.

We would add - I won't comment on the other numbers, because they are just minor changes that we have made - but we would add a few others rights at this point. The list is not exhaustive, but we do believe that one of the problems that we have come across is nursing home residents who could benefit greatly from physiotherapy and who are not getting it in their environment. The attitude being that this person is in the last stage of life and perhaps doesn't deserve the attention, money, and help needed for that person to become more mobile. We would like to have in our bill of rights a provision whereby the necessary physiotherapy or other rehabilitative care is available.

The Amendment Act doesn't deal with physical or chemical restraints. And again, there is a very important issue of consent and the consent to be restrained in certain situations; the right of review, both by the nursing home or by the resident should - in the case of a nursing home - if the person is not consenting to be restrained and the

nursing home feels that that is dangerous to the person, that should be addressed in some way. The only mention of physical restraint is currently under Regulation 55, and it is not satisfactory from the point of view of consent.

We would also address the area of research. As valuable as it might be, experimentation and research is a subject in which no one should be participating without their full knowledge and consent.

The right of a competent nursing home resident to manage his or her financial affairs is something that we believe would enhance a resident's feeling of independence. Now, when a resident or a person goes into a nursing home, virtually all the financial affairs are taken over by the nursing home, often in conjunction with the family, but there is very little reporting done. And again, it's a feeling of loss of control over your life. Why shouldn't a competent nursing home resident have the ability or the right to deal with his or her savings and to know, on a regular basis, what moneys are being expended on his or her behalf?

It immediately raises the question when you talk about a bill of rights of how you are going to enforce it. We have been grappling with this problem, and I'm sure the members of the Committee have been as well. Currently, they don't have to be enforced in any particular way because they are not rights in the Amendment Act. If they were made into rights, they would have to be enforced. How do you do it?

Firstly, having rights for residents should never exclude their right to bring a private right-of-action; in other words, their right to bring an assault charge or a civil action in negligence. And secondly, we think to ensure that both parties know what the rights are that the bill of rights ought to be in the contracts that are signed on admission to nursing homes, and that these contracts ought to be obligatory. I think the practice is quite uneven in the industry, and where some nursing homes have fairly complete contracts, others don't have written contracts at all.

The alternatives for enforcement are, and we have come up with three different alternatives, but what we have to keep in mind when we're looking at enforcement is that in most cases we are not dealing with equal parties. The nursing home resident has to continue living under the roof of the person alleged to be the offender and, in many cases - most cases - the nursing home resident does not have the financial resources to bring an action against a home or a staff member. There is a question of time. Any review process has to be a speedy process. We are dealing with people who may be in their eighties or nineties, and there simply isn't the time for protracted litigation.

We propose looking at arbitration as a possible means of enforcement, whereby an arbitrator would be appointed in a serious case. Our thoughts are that in a minor dispute with the nursing home, the residents' council could, in fact, try to resolve it, and that it shouldn't go any further than the residents' council if it is a complaint which can be dealt with in the here and now.

For a more serious allegation or one that cannot be resolved by the residents' council, then one possible alternative would be arbitration. And for those of you in the labour field, there are many ways of setting that up, and I won't go into any detail. I am not a labour specialist and Mr. Sugarbroad here is. He might be able to answer some questions in that area.

Another alternative would be a review procedure - and you can look at the Health Disciplines Review Board as a possible example, not that it's perfect - but essentially, a person, a resident with a complaint that his or her rights have been infringed, would set the complaint out to the Complaints Committee. A complaints committee would investigate it and would have certain powers of investigation.

One of their powers would be to appoint a conciliator - if that were appropriate - and the committee would make a decision on the complaint and that decision would be reviewable by either party, and it would go to a review board. Again, it has to be a speedy process and the time limits have to be very strict. So that we are looking at a decision by a committee in fifteen or twenty days and a review process that would get to the Review Board hearing, again, within two or three weeks. It can't be the normal judicial review process which can take well over a year.

Because sometimes residents do not want to initiate their own complaints, feeling intimidated, feeling for whatever reason that they don't want to be the noise makers, the Complaints Committee itself, if they feel there is a legitimate problem, can initiate the complaint, or it could be initiated by a family member.

The other alternative that we've looked at is simply attaching to the rights the usual penalties of enforcement, the quasi-criminal and civil penalties. And again, that would probably dovetail with the penalty system that currently exists under the Act - although that, we would submit, has to be beefed up as well.

The penalties, when you are looking at the bill of rights, should not necessarily be a fine levied against the nursing home payable to the state only. It could also be a penalty payable to the resident himself or herself.

I want to deal briefly with the residents' council and get away from enforcement for a minute, because the council has been proposed in the Amendment Act as being a vehicle for looking at disputes; and the three-tiered system which has been processed, to us, looks as though a lot of the inspection process and enforcement process is going to be handed over to the residents themselves. The Coalition thinks that this is probably unwise at this time; that by and large, residents' councils - while they may be the best vehicles for resolving minor disputes - are certainly not the people to be vested with a tremendous power of investigation and disclosure, getting disclosure of documents.

We think that a workable system would be to have one council, not to have a separate committee, and certainly not to have an adviser to the committee or the council. The residents' council would be composed of a majority of residents. Where you have your separate committee with separate powers, we would put those powers into the council itself. And in looking at the powers that you have given to the committee, there is no reason why the council could not deal with that in some way. What we would propose is that there be outsiders on the residents' council, that they be in the minority, they not be limited by geographical area, and The outsiders should not necessarily be experts in a certain field.

However, the outsiders, as I'll call them, must be people who are truly dedicated to improving the lives of nursing home residents, and also be effective in dealing with the operators of nursing homes, and effective in listening to the residents' complaints and the concerns that they might have.

The residents' council, because it would have the powers that are currently being given to the separate committee, they would have, hopefully, access to and, if necessary, funds available to bring in people with expertise, such as a nutritionist, for example, possibly an accountant if the council wishes to deal with a financial problem with the home itself. And that that be encouraged. However, when you are not a much more serious complaint, we don't believe - the Coalition doesn't believe - that the council should be the vehicle for investigating those major conflicts.

The penalties for breach of the Act, generally, as they are set out in your S.19(a), we think ought to be expanded into a range of penalties so that operators know what they're facing if they allow a home to be run in a substandard way so that even the lives of the residents are being threatened.

My personal thought is that \$10,000 is by far too low a maximum, and that there should be some re-thinking on minimums and maximums. However, by putting in a range of penalties, I think you can deal much better with the kinds of problems that arise.

The highest type of penalty would be for those infractions which cause serious bodily harm to residents or possibly death. The next level of penalties would deal with violations of the Act where the welfare or the safety of residents is at risk, but not necessarily the grievous bodily harm. And then you get into a lower type of violation in which the health and well-being, generally, of residents is being affected in some way. And then the lowest classification of violations in which there is no immediate or long term effect on the health of residents, but it's simply a, like a strict liability offence where certain matters are not being addressed by the home and they have to be penalized for that.

There should be other remedies available to the Enforcements Branch of the Ministry of Health; for example, suspending admissions to the home until the home improves its standard of care, or ceases the type of activity that it's guilty of; suspending or cancelling a licence, which, of course, you have already addressed in the Act and in the Amendment Act; and allowing probationary licences on condition that the infraction be remedied; and also, injunctive relief if necessary.

I won't be too much longer because, I believe, we have a half an hour for our presentation.

Mr. Chairman: You have an hour.

Ms. Purdy: We have an hour.

Mr. Chairman: Usually questions take a lot of time.

Ms. Purdy: We have addressed, in minor way, a number of issues, most of which are dealt with within the Amendment Act. But one, for example, staff and staff training will no doubt come in other amendments. But on the issue of staff and staff training, it's our view that the inadequacy of staff and the poor training of many of the support staff is a direct cause of a lot of the complaints arising in nursing home and nursing home care. The chronic under-staffing means that the health care aides are, in many homes, totally frustrated, working long hours and without the kind of support that they need, and without, you might say, the wages to reflect the kind of work they're doing.

In-service training courses, while they are required, are not being enforced. And in our experience, the nursing staff and the other support staff are saying that they are

being held at times when they can't get there; or they are held at night when they are off their shifts and are not able to come in. And of course, the Nursing Home Branch is not - as we see it - not enforcing the training. There should be courses in gerontology for anyone working in nursing homes, and they should be followed by every staff dealing with residents.

The administrators, we think, ought to be approved by the Ministry before they take over as administrators, before they are brought in as administrators in homes. Not only their formal education should be looked at, but also their ability as individuals to live and enhance the life of the nursing home residents. Again, they should have courses in gerontology and be suitable people to be running nursing homes.

We believe very strongly that the S.13, S.S.(3)3 of the Amendment Act which deals with provision of services by nursing homes should not include the provision of services to the community. It's our view that those services ought to be handled by the community -- I'm thinking of Meals-on-Wheels or day programs that some nursing homes are attempting to become involved in. That the wording of your Section ought to be that: "The Minister may enter into an agreement with the licensee for the provision of services for residents in addition to those provided for under this Act and the regulations."

And our thought is that this Section would be dealing with the provision of, for example, special care units for Alzheimer's residents, special physiotherapy services for residents. And there would be an ability for the Minister to work out a financial arrangement apart from the normal nursing home agreements, but not the kind of provision of services that we think properly belong in the community. If the intention of S.13 was to open the door for nursing homes to get into the provision of community services, we would say no; let those services exist and be developed in the community and have the residents from the nursing home join in and come out of their environment to take advantage of these services.

We believe that when it comes to the licensing - which is S.4 in the Amendment Act - that the public interest requires that there be public hearings and that the public interest in a specific locality, not just the province as a whole, should be addressed. We have the analogy under the OMB hearings, under the Planning Act, et cetera. And we believe that in order to really ascertain what the public wants and what the public needs there should be provision for public hearings.

We are not clear - at least in the Coalition - as to how much detail goes into applications by nursing home

operators, proposed nursing home operators, when they are asking for a licence. So, we have put in page 13 of our brief that the application for the licence ought to include the proposed staffing, the health care facilities, the social programs, and any special services planned, and that a condition for maintaining licence must be an undertaking to provide the services as promised in the application. We don't know if that is being followed up on at the moment and that the promises to provide services are promises in the air.

There is one small point we want to make about the transfer of control of a nursing home, and that's in your S.4(c). It deals with the private company under the Securities Act. And from our reading of these Sections, the private company cannot be transferred or cannot permit an issue or transfer of equity shares which would change its ownership or controlling interest without the prior approval of the director. It raises the question: Are there other ways of selling a company? And we think there are. And that this Section ought to be reworded to ensure that any means of transferring a business over - not just through shares, but by selling its assets or whatever - would require the prior approval of the director.

We looked at the following, S.4(f), to see whether that would cover the situation of one company selling out to another, but we don't think that that Section was meant to cover that situation. It talks about:

"A licensee shall not enter into a contract whose effect is to change the management of a nursing home or the ownership or controlling interest in the licence without the approval of the director."

As terminology in the margin says: "It's a management contract provision." So, I think we should look at that and ensure that any change of control in the private company should require approval of the director, or else the licence is forfeited.

Finally, we recommend that the Financial Disclosure section be improved so that there be a standard reporting system implemented, and that the statements for the annual financial statements that are presented be very detailed. Our understanding is that they are not, and the ones we have seen are very brief. The operating profit and loss for the year ought to be detailed, and the income including government subsidies, donations, breakdown of expenditures, the amounts expended on staff, staff training, recreation programs, heating, food, and rehabilitation services and management all be set out in their annual statements.

Just as a concluding statement, the Coalition is in favour of readdressing the imbalance between profit and

non-profit homes in the province -- given that we understand there is about ninety per cent for-profit homes. Our reasons for preferring non-profit, or a greater number of non-profit nursing homes, - I'm sure you have heard before, but you are welcome to ask us about it -- there may be communities where it is simply not feasible to implement non-profit homes at the moment. And again, we are not taking a hard position that there should be no profit homes in the province.

Our position is more that the province must look to providing better home care services for older residents, for older people, so that the trend does not -- to increase the number of people going into institutional care. That there are ways - and I know the province is looking at ways of home-sharing and providing special mortgage situations - so that senior citizens can remain in their own homes.

For the moment though, we do have a problem with nursing homes, and in some cases, inadequate care. And we feel that regulatory tools have to be given greater emphasis, and there has to be more teeth in the legislation to ensure the rights of the residents. So, we are open to questions, and we will try to answer.

Mr. Chairman: Thank you, Ms. Purdy for a very clear and concise statement. I have on the list Mr. McLean first.

Mr. McLean: Thank you, Mr. Chairman.

On page 4, item 5, you indicate each person shall have the right to participate fully in making any decision and the right to obtain an independent medical opinion with respect to a decision concerning his or her admission to the nursing home. But I think we all agree that they should agree if they -- that's when the decision is made that they should be in a nursing home. But what happens if they are in there for about thirty days, and they decide that they do not want to be in the nursing home any longer? On page 5, you indicate there that they have the right whether they want to be discharged or not discharged, and there is a review process. Is that review process not in place now?

Ms. Purdy: There's no, as far as I know, there's no formal review process when it comes to transferring a person from a nursing home or discharging them. And we know of one case at the Advocacy Centre where a person was transferred from a nursing home to Whitby - the psychiatric hospital at Whitby - and nobody consented to that. I mean it was -- well, the medical doctor has to do the - what's it called? - a transfer form, I believe. But the woman herself was not involved in that transfer and was given very little notice of it and her family wasn't aware of what was happening until after the fact.

So although, yes, there has to be some involvement by the attending physician in the discharge or the transfer, our concern is that the residents themselves be in control of that if they are competent.

Mr. McLean: What if residents ask for their confidential or personal medical records, and the doctor did not feel that was proper in giving them? You indicate in there that that should be a right that they have if they request them. What if the doctor feels that they should not see it?

Ms. Purdy: For psychiatric reasons possibly?

Mr. McLean: No, not really. Well, for any reason.

Ms. Purdy: Well, I can just think that -- If it's a psychiatric problem that would adversely affect the resident, then what you would want to add to the wording that we have is: "Unless medically contra-indicated." But knowledge of your records and what is contained in them is a right that we should all have. And if I were a resident in a nursing home, I would want to be able to see my records and what they said about me.

Mr. McLean: Thank you.

Mr. Chairman: Mr. Cordiano is next, but he is not in the room so we will update you, Mr. Cooke.

Mr. Cooke: Thank you.

It's your opinion that if we took the statement of principles and also used the statement of principles along with some of the additions that you're suggesting and made that a bill of rights as well, I'm assuming that you would want to maintain that also as a statement of principles for interpretation of the rest of the Act?

Ms. Purdy: No, I see no harm in that. Certainly.

Mr. Cooke: I was looking last week with Legislative Council at just simply having a bill of rights, and my understanding is that if we want to, it would be appropriate to have a bill of rights, but it would be helpful to have this statement of principles which is a guidance for interpretation of the rest of the Act and that it would be adequate enforcement; number one, have it automatically in the contract which all residents of nursing homes would have with the administration or the owners of the nursing home; and secondly, have a section that makes it clear that the breaching of the bill of rights is considered to be a breaking of this Act and subject to same penalty section as the rest. That would be an adequate enforcement mechanism?

Ms. Purdy: Well, not without putting your minds to whether the existing enforcement mechanism would cover the kind of infractions that could possibly happen. And that's why we looked at possibly enforcing the bill of rights through a separate mechanism, such as arbitration.

There are a number of ways in which the Act may be contravened now, which have nothing to do, necessarily, with the bill of rights. It could be a question of not having large enough pots in the kitchen or something like that, but it may have nothing to do with the health of the residents. It may be simply a breaching of the regulation that is not connected to the standard of care with the residents.

So, I recognize - we recognize - there is a real problem in setting out an appropriate enforcement mechanism for a bill of rights. But to suggest that they are rights the way it seems to be suggested now, we would say is simply misleading.

Mr. Cooke: No, I agree. The difficulty with arbitration is that well, many of us would have an idea how arbitration works in the work place. It doesn't. I mean, just trying to assess the Arbitration Board, and who would sit on the Arbitration Board, and how it would be set up, and who would appoint, and who would have standing and all the rest of it gets into, is a very complicated process that we may or may not want to do. The Ontario Nursing Home Association has suggested the concept of an independent complaints commission.

But I'm just wondering if, in fact, it would be adequate? For example, when you say that a person has the right to receive physiotherapy and other rehabilitation care, that is a fairly clear right that if it is not provided, shouldn't take a genius to determine whether or not it is being provided; and if it's not being provided, then there should be a charge under the Nursing Home Act, if we make it clear that the bill of rights is subject to the penalty section of the Act.

Ms. Purdy: That is certainly an alternative, yes. Just on the example that you gave though, it's the range of sanctions which must be addressed; and perhaps for this one resident who would benefit from a certain type of physiotherapy, the kind of penalty system under the Act may not address the real problem and the solution to the problem. Whereas, a review system, such as the complaints committee with recourse to a review board or a type of arbitration - custom-made arbitration - possibly might get to the solution of that problem, which is not necessarily the imposition of a fine. It demands a power in the arbitrator or in the review board or complaints committee to look at a number of options and even the participation of outsiders to be brought in. And then you can look at the

section of providing a service in the home for this particular person under the Act. So I'm just raising it that penalties are not necessarily --

Mr. Cooke: I like the idea; that's why I'm raising it. I mean, what would the next step be then if there was a complaints commission? Would there then be the right to appeal?

Ms. Purdy: There's has to be the right of appeal.

Mr. Cooke: Yes. You know the problem we have with the current Act that by the time you actually get to the point of taking over a nursing home - like Country Place - that actually puts the health and safety of residents at risk; it took sixteen months or thereabouts.

I would hate like heck to see -- I had two examples over Christmas that directly relate to physiotherapy or rehab of individuals who actually, formerly were involved in my riding association executive, so I went to visit them; and they had broken their hips. And I talked to staff, because anyone that knows anything about breaking a hip that after you have come out of the hospital that at the very least, you've got to be taken for walks so that you continue to utilize your legs so that you don't end up in a wheelchair for the rest of your life. The staff made it very clear: they don't have enough time for it so that they're in wheelchairs, and that is where they remain for the rest of their lives.

If we had a very extensive, lengthy process, in all likelihood by the time the process ended, the decision would be irrelevant to those people. They would already be in their wheelchairs, and there would be a very unlikely chance of rehabilitation working.

Mr. Sugarbroad: Doesn't that tie up with the whole question of the residents' council and making that council aware of what their rights are and that, for instance, physiotherapy is something that the nursing home should be providing by making the inmate aware of rights, I think, is one of ways in which you avoid this question of there not being sufficient provision of physiotherapy, for instance. It is a difficult case.

Mr. Cooke: Making people aware of their rights is going to be important if we have a bill of rights; however, then we do have to have the next step of making sure that someone who is aware of the rights can access some system to help them get those rights.

Mr. Sugarbroad: It raises the whole question of advocacy.

Mr. Cooke: Yes, it does, without a doubt.

Mr. Sugarbroad: Which is a separate item.

Mr. Cooke: Yes. In one of the other sections of the Act - I don't know if you addressed it - but when a director is determining whether an applicant has complied with specific conditions and the licence will be issued, then if the director determines that the licence will not be issued, the licensee has the opportunity to appeal; however, if the licence is approved and, for example, the residents don't approve of that, there is no opportunity on the contrary side to allow residents to appeal a positive decision. In other words, all of the rights are built in, in this case, for the licensee, but nothing for the residents.

Ms. Purdy: Are you talking about renewal of a licence?

Mr. Cooke: Yes, renewal. Do you think that it's a practical -- Again, I don't want to build into the legislation a system that needlessly holds hearings, but I don't want to have on the system a lack of opportunity for people to express their point of view.

Ms. Purdy: I think certainly - the Coalition would probably agree with me - that when it comes to renewal of a licence, that residents' council should have the right to make submissions to the director on the renewal of the licence, because they are the ones that are the most intimately concerned with the day-to-day operations of the home.

Mr. Cooke: Would it be adequate if we were going - instead of having a formal hearing - would it be adequate to have - call it a public meeting; call it whatever you want - but the opportunity for written and oral submissions to be made so that we can somehow stay away from a formalized hearing which would make the whole process impractical on a yearly basis?

Mr. Chairman: Just perhaps while the answer is being formulated, I have two other speakers.

Mr. Cooke: Okay, well, I only have one other question after this.

Ms. Purdy: Certainly written and oral submissions are advisable. And whether that should be restricted only to the residents' council or whether there should be the opportunity for the public, generally to --

Mr. Cooke: I would like to see the public as well as the staff.

Ms. Purdy: Because we have advocated on the granting of a licence that there be public hearings, certainly, on the renewal of licensing, we would take the same position. And there you have got a nursing home with a track record, and you've got something more concrete to deal with.

Mr. Cooke: Final question is with regard to the reporting of harm to a resident. And the final section says:

"Unless the other person acts maliciously or without reasonable grounds."

It is on page 13 of the Bill, S.17(a). Do you have any concerns about the possible use of claiming that someone has been malicious or acting without reasonable grounds?

We were told last week that potentially a member of the public could complain. The director could determine that the complaint was without reasonable grounds or was malicious, and we could put in the position of the Ministry of Health charging a member of the public for complaining about a nursing home, or a staff member, or even a resident?

Ms. Purdy: I haven't found the Section of the Act that you are referring to.

Mr. Cooke: You are on the -- you have the printed one. S.17(a).

Ms. Purdy: All right. I just want to look at the wording before I respond to that.

Okay, your concern is if somebody is acting without grounds?

Mr. Cooke: My concern is not that -- If someone is acting maliciously then I don't have great concern. My concern is a legitimate complaint, where somebody has acted in good faith, but that it is used as a deterrent. And my feeling is that the the law should err on the side of encouraging people to complain rather than having any section that might deter people from complaining.

Ms. Purdy: We would eliminate those words. And certainly, I would agree with you that when you are dealing, let's say, with an employee in the nursing home who has reported harm to a resident, that person shouldn't be disciplined by the nursing home.

In any event, they have their cause, their right of action under the law to dismiss an employee for cause, unless they are unionized; and then there would be, under the collective agreement they would their rights. I don't think that wording, "unless the other person acts

maliciously or without reasonable grounds" should be in there at all.

Mr. Sugarbroad: I think there is a part right in the very beginning that guarantees the rights of individuals to complain under this Act.

Mr. Cooke: That's the guarantee for the resident, I believe.

Mr. Sugarbroad: It's also for anybody else that complains and, therefore, it is a double cover, really. I can't think of the -- It's right at the very beginning, I believe, somewhere.

Ms. Purdy: The wording itself is really inappropriate, because you have got:

"No person shall dismiss, discipline, penalize coerce, intimidate, or attempt to coerce or intimidate another person because that other person has made a report, unless that other person is acting maliciously or without reasonable grounds."

Does that then give the nursing home the right to intimidate or coerce that person? I would take the wording out.

Mr. Sugarbroad: That's the point. I knew it was somewhere.

Mr. Chairman: Mr. Cordiano.

Mr. Cordiano: Thank you, Mr. Chairman.

Thank you for your presentation. I just have a brief question with respect to the residents' council and the fact that the Coalition rejects the council - the three-tiered approach. Your suggestion here is that the residents' council be empowered with more of the--

Ms. Purdy: --the committee's power.

Mr. Cordiano: --functions of the committee, yes. And that should be transferred over to the residents' council. And in effect, you are suggesting that we really don't have a need for a committee?

Ms. Purdy: Not as a separate body, no; no. How ever it is structured the council would be primarily residents, and then they would have in the minority a number of outside people who would. We think it is valuable to have outside help on a residents' council, that many councils will simply not work without some outside initiative. And yet, it is the residents themselves who ought to have the power

to advise the residents of their rights, to meet with the nursing home operators, to look at the inspection reports with the nursing home operators.

There is absolutely no reason why the council itself, with some outside help, cannot do any of the functions listed in the terms of the committee's powers and to mediate and resolve the disputes.

Our point was that we think it is possible for the council with outside assistance to mediate minor disputes, but certainly not the kind of complex problems that we've seen lately.

Mr. Cordiano: Well, certainly. A couple of things. First of all, the committee would be composed of a number of members from, elected by the residents' council to that advisory committee, in addition to a maximum of three members who are non-residents on that committee.

Ms. Purdy: You're taking about the committee as a separate body?

Mr. Cordiano: Yes. The the way it is stuctured.

Ms. Purdy: The way it is stuctured, yes.

Mr. Cordiano: The way it is structured in the Act. I would think that given what you are saying that the residents' council should not be burdened with actual inspection, and the kinds of complex matters that might have to be inspected or investigated - let's put it that way.

Would it not be appropriate, though, to have this committee - the advisory committee - doing some of that for the residents' council? And in a sense, with respect to enforcement, then report to the the residents' council, in which case that would prompt, perhaps, an investigation by the Ministry, the inspectors. I think that is what was envisaged by the Act, and certainly that is the process as I understand it.

Ms. Purdy: I think in reality what will happen is that the outsiders with the more active residents themselves will take the initiative on the various problems and go through the mediation if there is a problem to be mediated between a resident and the home.

Our certainty is that the way the residents' council is structured, there is no power given in the Amendment Act to the council itself. All the power is vested in the committee and the adviser. So, you have a totally powerless residents' council. You have given them nothing except the chance to meet. And by reworking the structure so that the advisory committee becomes part of council, then you have

the opportunity for the council itself - I mean, you may have some very smart, articulate people on the residents' council who can do some of this work with the committee and with the outsiders.

Our proposal is that you simplify it and that the people who will take the initiative will be in one place at one time to do it.

Mr. Cordiano: So, you don't see that, in fact, the members that are coming from the residents' council to be on the Advisory Committee, that is not sufficient. You are saying, it is not needed, that, in fact, you should have one committee or one advisory council and attach to it some outside members?

Ms. Purdy: That's right.

Mr. Sugarbroad: We think it's cumbersome in the way it is proposed. There is too much of it, you could say; whereas, a more simple form of organization will be able to function much better. And if you are combined and made that way, you would have both the influence of the residents and the influence of outside people who are also interested in securing the best possible conditions in the home.

Mr. Cordiano: In looking at the structure of it, I think it's the intention that the advisory committee would report ultimately to the residents' council and would somehow then - whatever work it is doing - then would refer that back to the residents' council, because indeed, they're the ones of the utmost concern and would likely be the last point of reporting for the advisory council, in addition to the adviser, which is attached to the advisory committee.

Ms. Purdy: I can't really add much to what Stan has said. We think it is very cumbersome and unworkable in the nursing homes that we've seen. It's just not going to work very well. The active people, whether they be residents or outsiders, ought to be together. And if they're able to take initiative on problems, fine. If they need outside - like expertise - the outsiders needn't be experts themselves. They need to be committed individuals.

Mr. Cordiano: From the community, I would imagine.

Ms. Purdy: From the community, that's right. They could be from senior citizens' organizations; they could be an independent advocate; they could be someone who has a real interest in the nursing home. And if they need outside expertise, they ought to have the facility to get that help if they need it. There will be councils in which very little happens that way, but we don't see the need to create three different bodies.

Mr. Chairman: Ms. Woodsworth has one answer.

Ms. Woodworth: There's just one point I'd like to add here, not to prolong the discussion. Whatever form this particular part of the Act takes, it seems to me, there's great need to bring into every nursing home the community around it. And it is not just to do a policeman's job because certainly that is not the function, but it is to bring into that nursing home a freshness, some imagination, some creativity, and simply an understanding of the needs of seniors. Not being watch-dogs, necessarily, but bringing this fresh approach in.

I think there's great value in having residents and community people sitting down together and looking at things - some of which are probably done with the best intentions but are all wrong.

Mr. Cordiano: So, what I understand you to say then is that the thrust is there, and the general direction is there. And, indeed, what this might do is allow for possibly the community to be more involved in the nursing home, and I think that is the general thrust of this section of the legislation.

You are not seeing any problems with that; you are opposed to the three-tier council level, or whatever you want to call it at this point. But you say it should be, perhaps, two levels.

I was going to ask you about the adviser and the role of the adviser attached to the residents' committee, but I see I'm taking too long, and I'll probably move on and allow someone else to ask that question, Mr. Chairman.

Mr. Chairman: Well, Mr. Callahan has a supplementary so that might be it.

Mr. Callahan: Just as a supplementary, if I might. In listening to your approach, it seems as though we're building a hierarchy of sort of a tribunal?

Ms. Purdy: You are talking about enforcement?

Mr. Callahan: Yes. As opposed to the way I read the Act. It is to create a bill of rights and recognize a bill of rights, and to do exactly what we just mentioned, allow people from the community to act as a watch-dog and make certain that those rights are enforced.

Now, the reason it concerns me if you are going the other route is that we've all seen - despite the fanfare as when the Charter of Rights was brought into being; it has been a field-day for lawyers and has, in fact, backlogged, to a large extent, many of our traditional judicial

tribunals and even administrative tribunals - and if you're suggesting this type of an enforcement mechanism as opposed to the watch-dog, keeping everybody on the narrow but having all the rules out there and being looked at by an independent body, I have some great concerns about the backlog and the situation we get into. And I'm wondering if you have thought about that?

Ms. Purdy: We have exactly the same concern, and we don't necessarily have the answer to enforcement. We've raised a number of alternatives; we've looked at the problem of needing a speedy resolution to these disputes, which cannot be resolved informally. There are problems in some nursing homes which cannot be resolved either by the residents' council or any other existing mechanism.

And our proposal is call a spade a spade. If these are rights that residents have, then they have got to be enforced in some way. They can't be rights in the air. If they don't have the rights, well, let's tell them that they don't have them; but if you're going to ensure a high standard of care for residents, then you have got to give them a means of arbitrating or getting some resolution to their problem. And one of the suggestions is that it be part of the general enforcement system of the Act as it stands.

The problem is that there are certain rights - as we called them - which are not easily enforced through the penalty system; and it raises the question: Should we look at a review mechanism? And believe me, we're the first to say that it has to be a simple and speedy method. I can't tell you right now what the best solution is. We know from the Human Rights Code, and the tribunals set up by the Human Rights Code, there is a tremendous backlog in having complaints heard and resolved. They go on two or three years, and I share your understanding and your concern of how a resident is going to solve his or her problem.

Mr. Callahan: Not only that, but you put them in the capacity of a litigant--

Ms. Purdy: No.

Mr. Callahan: --which makes the atmosphere in which they have to continue to live, perhaps, less attractive and less calm, which is what they need in a nursing home.

Ms. Purdy: Yes, I agree with that. But inevitably a person who complains is going to be singled out - at least feel that they're being singled out by the administration in some way. However, if you go through a review system, as opposed to taking your action to the Supreme Court of Ontario for negligence, the review system ensures that the person who lays the complaint simply becomes a witness in

that investigation and is not charged with seeing the process through from beginning to end.

The person registers the complaint; it is taken up by a complaints committee; the complaints committee may find that there is a simple way of dealing with it; they may make a decision that resolves it, or it may have to go to review. But the complainant himself, or herself, becomes a witness in the process as opposed to having to expend the energy, time, and money to process it themselves.

Mr. Callahan: Thank you, Mr. Chairman.

Mr. Chairman: Okay, Mr. Callahan. Mr. Andrewes.

Mr. Andrewes: Just briefly going back to the whole question of the residents' council. You said that the intent of the legislation should not be vested in the residents of a nursing home the obligation to investigate and solve all their problems within the nursing home. I was right with you when you said that. But then you moved down a little further, and you vested all that authority in the residents' council. And, I guess, my concern is that the residents' council under your proposal - under the current proposal - the residents' council advisory committee vest certain investigative authority in the council without giving them any powers to resolve, other than resolve them on an informal basis.

Ms. Purdy: Yes. Our concern with the proposed amendment is that it seems to be crossing the line between having the council or the residents involved in looking at problems and solving them and making them solely responsible for investigating. The concern was, when you empower a council to demand full disclosure of records, to enter into the nursing home at any reasonable time or whatever and check the books, you are really crossing the line into what the Ministry's function or its function properly is.

There was nothing that the committee is charged to do under your - under the amendment - which shouldn't be the proper function of a council. There is no reason why they can't meet with the licensee; there is no reason why they can't attempt to mediate; and there is no reason why they can't report to the Minister on various recommendations or concerns. But if you look at the actual powers of the committee, that is all they do. The adviser, yes, it has a different function - a much stronger role in this process. But the committee as it is currently structured is simply informally looking into problems.

Now, if the nursing home says, "Sorry, you want to bring an accountant in and look at our books; we don't want you to." All right. It's a problem that can't be resolved by the residents' council or committee or both. And then it

is something which has to be taken up by the Ministry. But we don't want the line crossed where the council is empowered to the extent that it is the sole investigative function.

Mr. Andrewes: So, essentially what you're saying is give the council the role which is now defined for the committee?

Ms. Purdy: Yes.

Mr. Andrewes: But don't give them those investigative powers, because - this may be putting words in your mouth - in my view would be that you create an expectation of that committee that they can't deliver on?

Ms. Purdy: That's right. You said it well.

Mr. Andrewes: Thank you. Can we go to your point about physiotherapy and rehabilitative care?

Ms. Purdy: Yes.

Mr. Andrewes: I guess I would be guided by the wisdom of legal counsel here, but my thoughts about a bill of rights essentially are that they are fairly broad terms. We get into specifics like rehabilitative care and physiotherapy. I would feel they more properly belong in the defined program of the nursing home rather than the rights of residents, because you could even get more specific than that and say, proper dental care, proper this and proper that. Well, that's why I think probably the area in which they belong is in the program more so than the bill of rights.

Ms. Purdy: You mean a program specific to each nursing home, and there would be nursing homes that would be capable of undertaking physiotherapy and that you would know had been going into the nursing home?

Mr. Andrewes: Basically, in my view, they all should have at least a - perhaps not a program, not specifically - but they should have rehabilitative care as one of their directions.

Ms. Purdy: I don't disagree in principle with that.

Mr. Cooke: Rehabilitative care is one of the rights that changes the very nature of nursing homes as we know them today. And isn't that the reason why it would be in a bill of rights?

Ms. Purdy: Well, yes. If you don't put it in the bill of rights then it is a question of whether the nursing home decides to implement that kind of care. And to date it

has been a hit-and-miss situation - mainly miss. And our position is that where you're in a facility, whether it be a hospital or a nursing home, in which you have a disability or an injury or whatever that would benefit from that kind of care, you ought to have it; it is a right. And that the eighty year old person has no less right than I do - simply because I'm not in an institution - to have that rehabilitation and the accessibility of rehabilitation.

Mr. Andrewes: Well, I don't disagree in principle. I guess I just find if you put it in a bill of rights, one is to ask where do you end; where do you stop? Because you may start defining virtually all the services that a resident in a nursing home might require and say that they are entitled to that under this bill of rights. And I guess, my view, in terms of looking for, and perhaps seeing it to some degree from the administrative side of the Act, it perhaps is more appropriately addressed under whatever section of the Nursing Homes Act; it says that: "A nursing home's obligation to its residents are..."

Ms. Purdy: You mean you see it as an obligation of the home as opposed to a right of the resident?

Mr. Andrewes: Yes.

Ms. Purdy: I don't agree, but I can't really add to the...

Mr. Sugarbroad: Since you've seen many more of these briefs from other organizations, it may be that they can more solve that problem. We need to figure out the problem, more personally, I believe. That to consolidate that position either way is an improvement. That there should be facilities for physiotherapy one way or another. That is the thing we really want.

Mr. Andrewes: That's right.

Mr. Sugarbroad: If we could get it set either way, we would be happy with that.

Mr. Andrewes: Okay. We go then to, just briefly, to the question of your statement that nursing homes should not be providing community services. I find a little conflict here in that you're suggesting that the residents' council be expanded to include members of the community, but yet you're saying that the nursing home as a focal point for care for the elderly in that community should not be delivering services out into the community?

Mr. Sugarbroad: In some ways it is a contradiction. We are, and have been, very interested and put up considerable arguments for the community to play a bigger role in the keeping of people in their own homes - keeping

the elderly in their own homes. One of the big things that evolved from that is that the government must provide the necessary means by which they can be kept in their own homes. And one of those will be things like a one-stop system and community health care and so forth.

Now, if we allow this particular thing to develop from the nursing home to the community, we are contradicting what we are putting forward as an important part of keeping people in their own homes rather than institutionalizing them.

So, we see this as possibly a dangerous precedent. We would rather that the community begins to provide the services to the elderly, and not the nursing home, as an outside source to the community. I hope you get the point we are trying to make.

Mr. Andrews: I just don't agree. I think the two can be quite complementary and, perhaps, there are occasions in a smaller community where the nursing home is the only facility that is in that type of position.

Mr. Sugarbroad: Well, we would make a point on that.

Ms. Purdy: Well, in a smaller community, yes, the nursing home may be one of the focal points of a community. I can't think of one where it is, but shopping malls are also a focal point of small communities. And many small communities now have drop-in centres or community centres of some sort. And I don't think we should look to the nursing home to be providing services that properly belong in the community, and which, in turn, can also draw the residents out of their home on occasion to take part in a day program outside of their institution. It integrates them more into the community and keeps them from being totally isolated. And I see no contradiction in having community people on residents' councils. Because again, it is facilitating a closer bond, a closer understanding between the people in these institutions and the community.

Mr. Andrewes: I agree with that; I don't see any contradiction having the community and the residents' council. I guess, I just see instances where you wouldn't want to be restricted -- where the Minister or the director would not want to be restricted from approaching a nursing home about providing a certain service in a community, because it may or may not be the only facility in that community that could provide that service.

Ms. Purdy: There may be exceptions; I agree there maybe exceptions.

Mr. Andrewes: Okay, and just one final point, page 13, it says, "It is imperative that unlicensed nursing homes

be dealt with severely." I wonder what you mean by unlicensed nursing homes?

Ms. Purdy: Well, nursing homes, of course, are supposed to be licensed. Under the Act they have to be licensed. But we know of cases where senior citizens' residences are, in fact, developing areas of their building into a nursing home. So that one floor, for example, of the building is operating as a nursing home which is not licensed. And although there are sanctions under the Act, I don't believe that the Ministry of Health -- Well, there are minimal fines for operating as an unlicensed nursing home.

And I think, the Ministry needs more powers to go into places like this and investigate them, and I don't believe the powers exist in the current Act.

Mr. Andrewes: Are you speaking of retirement homes, rest homes, whatever they're called?

Ms. Purdy: Possibly, yes. Which are, in fact, taking on the role of nursing homes in some cases.

Mr. Andrewes: Without provincial sanctions?

Ms. Purdy: That's right.

Mr. Andrewes: At the residents' expense?

Ms. Purdy: That's right.

Mr. Chairman: One last question, Mr. Andrewes?

Mr. Andrewes: No, no. Thank you very much.

Mr. Chairman: Well, we appreciate very much the time you spent with us. It's been a very full half hour stretching it into an hour and a half which I think speaks a lot of the quality of the presentation and the kind of assistance it has been to the Committee.

Ms. Purdy: Thank you.

Mr. Sugarbroad: Thank you for your sympathetic hearing that you've given us.

Mr. Chairman: It's our pleasure.

Mr. Chairman: The final deputation is Dr. Franklin. He's been waiting patiently. Has this been circulated to the members?

Welcome, Dr. Franklin. If you're comfortable, the process is that you take us through the brief any way you would like then we'll open it up for questions. As you've

seen with the previous group, they range from just a few questions to quite a number. All the members have a copy of your brief.

Dr. Franklin: Thank you, sir. Mr. Chairman and members of the Social Development Committee, this is a submission by Alexander Franklin, physician, Bachelor of Medicine and Surgery, London University, 1959; licence of the Medical Council of Canada, 1971; Federal Licensing Examination (U.S.A.) 1974; Diploma of Physical Medicine and Rehabilitation, United Kingdom 1964; Diploma of Public Health, Toronto, 1974; Diploma of Industrial Health, Toronto, 1975.

In 1980, I was appointed part-time Chief Physician, Senior Citizens Programs, Ontario Ministry of Community and Social Services. My duties included visiting doctors recommended by the various homes for the aged and advising the Ministry as to their suitability as medical directors. I also made the report which led to the investigation into the state of the Metro Toronto Greenacres Home for the Aged in Newmarket.

Mr. Chairman, I would like to suggest that nursing homes be classified as psychogeriatric hospitals. As such, they would be removed completely from the control of those whose aim is personal enrichment.

The patients of these so-called nursing homes are usually senile, and they need all the facilities of a community hospital for diagnosis, treatment and rehabilitation, the aim being to reduce to a minimum those persons requiring institutional care.

During a recent visit to Toronto of a London University Professor of Psychogeriatrics, Dr. Brice Pitt, author of Psychogeriatrics, now in its second edition, at a lecture to the Ontario Psychiatric Association, Professor Pitt stressed the need for continual expert re-evaluation of the psychogeriatric patient. Many of Professor Pitt's patients go home. Admission to a so-called nursing home should not be a life sentence.

Sadly, there are patients in so-called nursing homes who are not senile. They could be patients with chronic chest disease who need day or night portable oxygen or who have urinary catheters in place. At present, they are prohibited by law to remain in a home for the aged where residents are usually mentally normal.

I would like to suggest, Mr. Chairman, that there is urgent need for separate facilities for the young, 20 - 30, and middle aged, say 40 - 60, mentally vigorous, chronically sick -- those, for example, following a stroke, multiple sclerosis, Parkinson's disease and quadriplegia.

Mr. Chairman, there are well-meaning principles in Bill 176 regarding the right of the patient to refuse medical treatment or medication. The Bill states that an independent medical opinion can be obtained for any proposed medical treatment or medication. I suggest it should also stress the fact that at present a patient has the right to be treated by their own personal physician and not necessarily the doctor chosen by the owner of the nursing home.

The principle of a residents' council is fine in theory; however, as most of the nursing home residents are senile, there is not a great deal of sense to the idea. The few mentally normal people who really should not be in a nursing home will dominate the residents' council.

The new post of salaried residents' council adviser will provide about 367 new jobs for social workers and nurses, but they will not cure the cause of the problem. The less that is spent on a nursing home resident, the more profit for the owner.

As to the physical facilities of nursing homes, no provision is specifically made for open air exercise -- so important in Canadian culture and one of the ways of life that gives Canada its identity.

Patients in these facilities can be condemned to spend their last years on a single floor, never going outside until the day of their funeral. As with parking requirements in new business buildings, nursing homes should have sufficient outdoor recreational space to allow for sporting activities. Mr. Chairman, I would like to suggest that sport be included as a patient right.

The advantages of sport for the mentally and physically handicapped have been well known for the past forty years due to the pioneer work of the late doctor, Sir Ludwig Guttmann, Order of the British Empire, who, of course, started the Wheelchair Olympics.

Mr. Chairman, in the explanatory notes to Bill 176, profit-oriented and non-profit oriented nursing homes are mentioned. I suggest there is no logical need for the word, "oriented." Ninety per cent of the nursing homes in Ontario are operated for profit without any question of orientation, often by large concerns with many homes. So-called nursing homes are an excellent form of property speculation. Large buildings appreciating in value while the costs are being paid for by the public. At a later date, the owner could convert the nursing home to a private retirement home at a much higher daily rate, to an hotel, condominium or business offices.

I suggest that the people of Ontario be the ones to benefit from the unearned increase in the value of nursing home properties, this through the takeover by the province of these facilities. As many are not suited for their present purpose, they could be used as low-cost accommodation, such as youth hostels.

I would like to suggest that the management of psychogeriatric facilities be given to a separate commission similar to the Workers' Compensation Board, which could interface the Ministry of Health and the Ministry of Community and Social Services.

Respectfully submitted.

Mr. Chairman: Thank you, Dr. Franklin, for your unique presentation and extra stimulating in terms of the parameters of the Bill that is before us.

Mr. Andrewes.

Mr. Andrewes: The premise of your brief is that nursing homes become psychogeriatric hospitals. What sort of entry point -- How would one make the appropriate determination that the individual belongs in a psychogeriatric hospital?

Dr. Franklin: Sir, after evaluation by a psychogeriatrician, or if a psychogeriatrician is not available, a psychiatrist or a geriatrician.

Mr. Andrewes: Is the current system -- Well, I would assume you're going to tell me current system of evaluation is not appropriate?

Dr. Franklin: It could be improved.

Mr. Andrewes: In what manner?

Dr. Franklin: The evaluation is appropriate, but the classification of nursing homes is not up to date. It gives a false impression of its function, and "nursing home" implies provision of nursing.

What is required is much wider facilities than I mentioned is provided by community hospitals. Does that answer your question?

Mr. Andrewes: Yes. As I understand what happens now is that an individual is -- a family physician is asked to make an assessment as to the individual's needs, and if that individual requires more than an hour-and-a-half of nursing care a day - I'm not sure I know what that means, "nursing care" - then they qualify to be in a nursing home.

I'm very interested in two things that you're saying. One is that the assessment process needs to be improved. I'm also very interested in the concept that a psychogeriatric hospital can, in fact, improve the state of the patient so that they can return to the community?

Dr. Franklin: Correct.

Mr. Andrewes: I think you've responded to the first part of my question. I wonder if you might elaborate on the second part, and that is, how do we improve the facilities and the system to assist people in rehabilitation as well as maintenance?

Dr. Franklin: Mr. Andrewes, I'll suggest that before -- taking the present situation - the so-called nursing homes - that the assessment could be done in an assessment unit in a community hospital. And this would give a more precise assessment, because now the family physician has to take the assessment really of the relatives in filling up the form as to how the patient can feed, dress, wash, and other private activities which the doctor may not actually have seen the patient do themselves. So at the present moment now part of the evidence you might say is hearsay.

Now, in an assessment in a geriatric unit in a hospital, or if they do not have one - if it's a small hospital - a general medical ward, one could actually observe these points. And I believe one has to have a certain number of points to gain admission by, say, maybe twelve. The number of the points must add to that for admission, I believe. So that the most efficient way would be the period of observation in the hospital. It wouldn't take long; a day or so. It's not expensive.

Mr. Andrewes: I assume coming out of that would be the patient - the individual - and the individual's family, and the physician would then be in a better position to judge the appropriate facility for that person to be in?

Dr. Franklin: Exactly, sir.

Mr. Andrewes: And that appropriate facility might be three or four weeks of curative care and send them back home again with the right community-based service?

Dr. Franklin: It might indeed, sir.

Mr. Andrewes: Thank you.

Mr. Chairman: Thank you, Mr. Andrewes. Mr. Callahan.

Mr. Callahan: I'm interested in your fourth page where you suggested the takeover by the province of these

facilities. You're suggesting they be expropriated, I would think. Is that --

Dr. Franklin: I don't know the exact legal implication of the word "expropriation," but the responsibility one way or the other would be taken over by the province or whatever the legal and financial mechanism that can be arranged.

Mr. Callahan: I presume you're suggesting at a fair market value. You're not suggesting that we just --

Dr. Franklin: Oh, I would say so. Yes, equity is always a good policy.

Mr. Callahan: Just to go back to, if I could doctor, your question about -- If I understand you correctly, you're suggesting that these people be maintained briefly or perhaps at a longer period of time within a hospital facility occupying what could be used for acute-care beds; is that what you're suggesting?

Dr. Franklin: Oh, yes. Yes, indeed. Yes, indeed, Mr. Callahan.

Mr. Callahan: Well, the difficulty I would have with that is that that's presently what's going on, is that many patients are, in fact, occupying acute-care beds certainly in hospitals in my riding, to the detriment of the availability of acute-care beds.

Dr. Franklin: Mr. Callahan, in reply to your question, I did imply that it would only be a day or so. Really, these patients would not be admitted with the idea of chronic stay. We're really talking about -- I would suggest, that there would be an outside limit of three days, and very often that could be done at the weekend when there is, on the whole, less activity so the patient could be admitted on a Friday night and discharged on Monday morning.

Mr. Callahan: Where would they go after that?

Dr. Franklin: Go back home or to whichever facilities; these are assessments. The patient has come in the home in a mobile state so that they come in for assessment. It's rather like a minor operation that takes a day, the whole idea being that, in fact, the facilities of the hospital could be well utilized because sometimes things slow off at the weekends so that that might be quite a good idea.

Mr. Callahan: I got the impression that you were suggesting - and I could maybe follow that line of reasoning - that the geriatric hospital or geriatric facility, for want of a better term, might be set up in a

campus-style medical facility where they would have access to all of the necessary medical assistance; you're not suggesting that?

Dr. Franklin: Yes, Mr. Callahan. I believe this is already the case with some non-profit nursing homes in association with certain hospitals - Northwestern and North York - which is an excellent idea. This gives the patients the chance to be examined by specialists in all the different fields and have all the treatments which we heard earlier - physiotherapy and rehabilitation - which would avoid the cost of duplicating the services already being in the hospital, and they could go to the hospital by a simple means such as underground tunnels. It's already being used in central Toronto teaching hospitals, and one could therefore give the patients the full advantages of the whole of modern medicine.

Mr. Callahan: Okay. Just finally, if I might, I gather from your presentation that your concern is that the majority or the large majority of people who are in nursing homes today shouldn't be there?

Dr. Franklin: The patients being senile should be in a psychogeriatric hospital. I suggest the present nursing homes don't have the facilities of a psychogeriatric hospital in that they do not have the medical expertise; they often have only family physicians regular visiting. And what are needed are geriatricians and the various services I mentioned before.

Mr. Callahan: Thank you, Doctor.

Mr. Chairman: How many psychogeriatric specialists are there in Ontario?

Dr. Franklin: I couldn't give you a precise number, sir, Mr. Chairman.

Mr. Callahan: It's very small isn't it -- the number of --

Dr. Franklin: They are increasing steadily. I believe the Royal College now has more and more candidates taking this specialist examination.

Mr. Chairman: It would be interesting to know.

Do you have any idea where we could find that out?
Thank you.

There are no other questioners, so thank you very much, Dr. Franklin, for taking the time to come and present this. We should hear from private citizens as well as groups and organizations.

We are adjourned until tomorrow, but we meet tomorrow in room 228, all members. So you should take everything that you have here with you; this room will not be available to us tomorrow. The meeting is now adjourned.

The Committee recessed at 4:58 p.m.

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

NURSING HOMES AMENDMENT ACT

HEALTH FACILITIES SPECIAL ORDERS AMENDMENT ACT

TUESDAY, FEBRUARY 24, 1987

Morning Sitting



STANDING COMMITTEE ON SOCIAL DEVELOPMENT

CHAIRMAN: Johnston, R. F. (Scarborough West NDP)

VICE-CHAIRMAN: Allen, R. (Hamilton West NDP)

Andrewes, P. W. (Lincoln PC)

Baetz, R. C. (Ottawa West PC)

Callahan, R. V. (Brampton L)

Cooke, D. S. (Windsor-Riverside NDP)

Cordiano, J. (Downsview L)

Cousens, W. D. (York Centre PC)

Hart, C. E. (York East L)

Jackson, C. (Burlington South PC)

Reycraft, D. R. (Middlesex L)

Substitutions:

Davis, W. C. (Scarborough Centre PC) for Mr. Cousens

McLean, A. K. (Simcoe East PC) for Mr. Baetz

Clerk: Carrozza, F.

Witnesses:

From the Ministry of Health:

Hart, C. E., Parliamentary Assistant to the Minister of Health
(York East L)

Sapsford, R. T., Director, Nursing Homes Branch

From the Association of Caring Friends of Ontario Seniors:

Hall, D. C., President

Richardson, V., First Vice-President

Barnard, J. L., Treasurer

From the Council on Ageing:

Strachan, N., Education Co-ordinator

Burns, B.

Evans, D.

LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Tuesday, February 20, 1987

The committee met at 10:05 in Room 228.

Mr. Chairman: I call the committee to order. It's 5 after 10, and our executives being here and the forum also being present, one of those amazing conjunctures of things which so seldom happen around here, I would like to therefore call forward our first deponents this morning, Ms. Hall, Mr. Barnard and Miss Richardson, from the Association of Caring Friends of Ontario Seniors. Would you like to come forward?

Ms. Hall: Yes, thank you.

Mr. Chairman: Come up here in front of me. Make yourselves comfortable. May we offer a welcome first, and the way we operate is to allow you to introduce yourselves and then make your presentation in any way that you would like to and then I open up to questions following that.

Ms. Hall: How long do we have?

Mr. Chairman: We'll give you about 45 minutes or a little longer.

Ms. Hall: Okay, fine.

Mr. Chairman: Do we have a copy of your brief or anything? There's no copy of a written brief?

Ms. Hall: Actually, we did not have time, but we would like to submit to you a copy of a letter which the association sent some days ago to the Honourable Minister of Health which pretty well sums up, and if we have time, we would like to clear through our membership a written submission. What is the final date?

Mr. Chairman: Well, we'll probably be going clause by clause for consideration by next Monday, starting next Monday afternoon, by the looks of it, but that -- or Tuesday. It's really difficult to say at this point, so it's fairly soon.

Ms. Hall: Well, we have an association meeting tonight, so we might be able to get it. But if not, this letter to Mr. Elston pretty well sums up many of the things that we hope to see in the amendment.

Mr. Chairman: Perhaps I can get the clerk to make a copy of it for the members. Would that be possible?

Ms. Hall: Yes, that's quite easy to do.

Mr. Chairman: Why don't you make, introduce yourselves now and make your presentation any way you'd like.

Ms. Hall: Well, I'm Dorothy Hall and we have -- I'm the president of a new association which is situated in the Harriston-Mount Forest-Palmerston area, the Association of Caring Friends of Ontario Seniors, and I have two of my executive officers with me. They will introduce themselves.

Ms. Richardson: Yes, I'm Vera Richardson, first vice, helping hand, I hope, to the same association, and very concerned.

Mr. Barnard: I'm Monty Barnard, treasurer of the same association.

Mr. Chairman: Welcome to all of you.

Ms. Hall: We're very pleased to have an opportunity to address this committee. We're a new association. We're an association large of rural and small town persons, and we number at the present moment about 80 members. The association is growing, and we're looking forward to having an association with groups in neighbouring towns.

Now, in general, the association supports the proposed amendments to the bill. We would like, however, to comment, first of all, on what our association views as a serious omission from the list of amendments, and second, on sections which we believe need to be changed in order to better protect the rights of seniors.

Now, first of all, our association wishes to bring to your attention the urgent need for amendments, particularly to Sections 56 to 59 of the original act. We can't see anything being addressed to those sections in the material which we have had. These sections deal specifically with nursing care and lay down the basic minimum numbers and kinds of nursing personnel which must be employed in a nursing home, as well as the basic minimum number of hours of care which must be available to each resident of the home. This number of hours currently stands at 1.5 hours per day, a large majority of which can be provided by the worker called a nurse's aide.

Caring Friends maintains that this amount of care and the level of preparation of those who can provide it is grossly inadequate. We believe that neither safe nor effective care can be given where this minimum is adhered to. We strongly recommend that the basic minimum be raised to 2.5 hours per day, and that the registered nurse must be made available to provide a minimum of 1 hour per day of this care. Now, at the present moment, she is required to provide three quarters of an hour per week, and we find this ludicrous.

We further recommend that the amended act should contain a section which stipulates that primary nursing shall be the method employed in all nursing homes, and this is a method whereby one registered nurse or a joint practice of registered nurses carries a case load. In other words, they are responsible for the planning, implementation and evaluation of the care of a group of residents. This would mean that every resident would have a registered nurse who was his or her nurse. And in this manner, accountability for the

nursing care provided would rest with a professional nurse.

We find it unacceptable that the physician should be named as the supervisor of the nurse and strongly recommend that wording in the act which places the nursing care under the direction of a physician be removed, and this is all through the act. The physician, we believe, is no more qualified to supervise the nursing than the nurse is qualified to supervise the medicine.

And we know very well in the homes that we are familiar with that the doctor visits the home perhaps once a month at the most, and it is ridiculous to think that he supervises the nursing care. And what is happening in the homes that we are familiar with is that the responsibility is being shuffled between the director of nurses and the physician, and if you go in and ask about care, they'll say, "Oh, that's up to the doctor to order." Or the doctor will say to you, "Well, the nurse is supposed to have done that."

So we believe that nurses in Canada are professional persons and they should -- they have under law, anyway, accountability, but they should be given authority to plan, to implement, and to evaluate the care given to residents in the home, and they should be accountable to the public for this.

We also believe that every family needs some one staff member in the home to whom they can relate, and the primary nurse is the obvious person for this relationship, so that the family can sit down with the nurse and say, and with the resident hopefully, "What is the plan of care for my mother?" And then the nurse can say, "Now, let us discuss how we jointly, along with the resident, will implement this plan and how we will evaluate the outcome of the care."

We find in the homes that we know that there's no standard evaluation of outcomes at all. And as the act is written, accountability for nursing care, as I said, is shuffled back and forth between the physician and the nurse. And we do not understand why the Registered Nurses Association and the Council has not brought this up long ago and had this changed in the act because it is, in a way, antediluvian. And certainly after the sessions that you have had here in Toronto recently, we know where the accountability lies in law with the nurse.

Now, the association is well aware of the current high costs of maintaining a resident in a nursing home. The owners and administrators of local homes with whom we have discussed the poor quality of care provided to residents tell us that they do not have money to provide for more staff. We are of the opinion that money is not the problem. The problem, we believe, lies in the use and management of existing funds and in the very obvious fact that in many homes, these homes are dedicated not primarily to the provision of high quality of care to residents but to making money for their owners. And we have worked out how much goes into local homes, and we are astounded at what the public purse is paying. And we think there needs to be a much better use of that money.

Now, this leads us directly to comment on Section 17c of the, which is related to financial statements. Caring Friends wishes to see in the law a well developed section outlining in detail what this financial statement must contain. Now, at the present moment, as you know, there is a suggestion that there will be details, but we don't know what those details are. And knowing well how a financial statement can be presented to hide anything you wish to hide, we would like to have it spelled out so that -- we believe that the public has a right to know just how much profit is made by the owner of a home, what is spent on items such as nursing staff, food, recreation, activity, home improvements, and what portion of income is directed to capital and running expenses. In our particular area, we are very taken aback by the fact that one nursing home group is buying up nine of the local homes. And we believe that the money that should go into residents' care is being used for monopoly in terms of homes in the area.

Now, the nursing home industry is one of the few no-risk businesses in our society. As you well know, the income of nursing home operators is assured from the public purse, either from direct payments from that purse or through the fact that the large majority of all residents are in receipt of old age security and/or income supplement payments, through which they meet their portion of the monthly cost of care.

Caring Friends believes that it is time that the few, but nonetheless far too many, nursing home operators who do not provide an acceptable level of care to residents are promptly made to improve the care or are required to relinquish their ownership to those who will do so. We believe that without increasing the cost, either to the public purse or the individual residents, a far higher standard of care is possible of achievement. Caring Friends believes that it is time that the people of Ontario who finance directly this most profitable, no-risk business have a significant input into its management.

The association has further instructed me to bring to your attention the fact that we have grave doubts regarding the capacity of most nursing home residents with whom we work to carry out the functions which are envisioned for the residents' council and the residents' council advisory committee, and that's Section 17d(1) through (4). Many residents that we know are physically and mentally too frail to engage effectively in the kinds of activities which are listed for them.

In the settings with which we are familiar, both residents and their families are most reluctant to speak out, even about gross inadequacies in care, because of fear of reprisals. And let me tell you, ladies and gentlemen, this is a very real thing in our area. The total dependence of most residents on staff in the home places them very much in the position of a hostage who is now to be requested to negotiate with the persons who are, in effect, their captors.

We concede residents' councils working well in settings such as residential homes, et cetera, but without strong support and direct participation of knowledgeable and active persons who are completely outside the nursing home setting and who have nothing to lose by

speaking out against neglect, we have grave doubts regarding the effectiveness of councils in the nursing homes.

And it's very interesting that just yesterday in the Kitchener-Waterloo paper there is a note about the fact that the nursing home that was closed here a few days ago by the ministry, that there had been no reports from the residents' council of anything, and we feel that this is very much what would happen in our own area. Residents are not prepared to speak out.

We recommend the establishment of some type of community-based boards who will work cooperatively with and where possible through residents' councils, to ensure that standards in all aspects of care are being met and who are in power to take action if they are not. We find the three-tier system that is proposed in the amendment to be very clumsy. We doubt very much if the third tier would be too effective and we would like to ask -- are we permitted to ask questions here?

Mr. Chairman: Rhetorically and then you'll get them picked up in questions to you.

Ms. Hall: Fine. Is this person who comes, we don't know where from, but probably from Toronto, going to be effective in our settings?

We have little or no faith in the current nursing home inspection system, as we daily see the results of its ineffectiveness. The inspectors with whom we have had contact through their reports appear to be oblivious to quality of life situations such as poorly and improperly dressed and groomed residents; poor quality of food, badly served; residents who are allowed to lie in wet beds; residents brought to meals without their dentures in place; pathetic activity programs, no family support system in the home, and a host of other inadequacies which are obvious to the lay visitor but seem to be lost on the inspectors.

We do not understand. We can go into these homes every day and we can list these things, and we ask for the inspectors to come up and what we get is a trivial list of small things that the home owner must do. And let me say, ladies and gentlemen, that we feel that the abuse in these homes is not the kind of abuse which is open and seen. It is a plethora of small things day by day which absolutely dehumanizes the resident.

Now, these, in effect, are our major points that we would bring across to this committee. I would say that we feel very strongly that what you have as amendments are good, but they're going to be largely cosmetic unless you put in more staff and unless that staff is then made accountable for the care which they provide.

Mr. Chairman: Thank you very much, Ms. Hall. That was a very clear and strong statement. Mr. Cooke has some questions for you.

Mr. Cooke: I would like to ask a couple of quick questions. I have to be over at the Ministry of Health for a briefing on a local health problem shortly, so I appreciate the opportunity to ask you a

couple of questions before I leave.

Could you just outline for me why your group started and how your group started?

Ms. Hall: Yes, our group started because one of the nursing homes in our area changed hands, and the staff in that nursing home came out to the public to say that the care had deteriorated to the place where they felt it was unsafe. And there were a number of public meetings, and the public was very worked up over this and we began to hear more and more complaints that had been, that were brought out into the open at public meetings. And out of that grew this association.

Mr. Cooke: Who bought the home?

Ms. Hall: Well, it's Crescent Care.

Mr. Cooke: Which home are we talking about?

Ms. Hall: It's the Harriston. It's called Gericare. It's the Harriston home.

Mr. Cooke: I remember the meetings, I remember, and then recently in your area there's also been a few other homes that Crescent Care has purchased.

Ms. Hall: That's right, there's been the Taverstop, which we have worked with the Taverstop group. And they are having, not the same type of problems, but associated problems.

Mr. Cooke: You outlined in your presentation in a very straight-forward way and a very clear way the problems with the lack of these amendments addressing the staffing problem whatsoever, and we certainly share those concerns. I'm not sure what we in the opposition parties can do because in the process of legislative reform, we in this committee can only amend the sections of the legislation that the government has opened up by its amendment act, but we are going to look at drafting -- my caucus is drafting one amendment that would convert the current statement of principles at the beginning of the proposed amendments and would maintain it as a statement of principles, also set it up as a bill of rights and an additional amendment that would say that the home must be staffed to meet the requirements under the bill of rights, which is not quite as precise as you would like to see it, or as I would like to see it, but it's the only way at this point that I can see that we can attempt under these circumstances to try to address the staffing problem.

I would like to get a better idea because it's one area that I don't think has been addressed before, of exactly under the current circumstances -- and maybe Mr. Sapsford can address this -- in the homes now, who is actually responsible for case management? And the suggestion that this group is making, I think, points very clearly to the problem that relatives have of not knowing exactly who to talk to. Is it the doctor, theoretically, that is the only one in charge of case management at this point?

Mr. Chairman: Mr. Sapsford.

Mr. Sapsford: Thank you, Mr. Chairman. The physician would be responsible for the medical care and for determining the care that should be provided by the nursing staff as has been outlined. As far as the nursing care is concerned and the way it's delivered, that would really fall under the responsibility of the home, and, consequently, the director of nursing care, the director of care is the titled area, would be the person responsible for implementing the care plans in the home.

Mr. Cooke: I certainly like your idea of having somebody who is directly responsible that the resident and the relatives of the resident can go and speak to and who is directly accountable for case management. I think that that's a good proposal. I'm not exactly sure how -- I don't think we can do it under these amendments, but certainly when it comes time to review the entire Extendicare Act, I think that is something that is absolutely essential, because relatives now have no idea how to go about complaining, other than to the administrator of the home or to the nursing home inspection branch.

Mr. Chairman: Mrs. Hall.

Ms. Hall: You see, one of the things that disturbs us is the fact that we believe that neither the medical or nursing profession are really addressing their responsibilities. We know in the nursing profession that primary nursing is relatively new but not that new and that it is, if you like, the state of the art in nursing. This is not being applied in these homes. Now, nurses are registered and licensed against competence, and I would think that the council -- in fact, we intend to approach the Council of Nurses because we feel that the nursing care is so abysmal in these homes, and we also have a great empathy with the staff because there's so few on the grounds. But primary nursing is certainly something that should be introduced and should be required in these homes.

Mr. Elston tells us by letter that they are now in the process of discussions with the Registered Nurses Association of Ontario and with the Council of Nurses. This is fine, but these things have been going on for a very long time, and let me say that our group does not understand, as a group of ordinary citizens, how Canadians can go over and over this, and we have years of reporting in our documents, and do nothing about it.

Mr. Cooke: One other question. Currently under the process of a license renewal, after the annual inspection renewal or the purchase of a home, so therefore the transfer of a license, or the establishment of a new nursing home and therefore the issuance of a new license, there's no opportunity for the public, for the residents, or for the relatives of the residents to participate in that process. Would you support an amendment that would put in place the provision for public hearings on these matters?

Ms. Hall: I would think so.

Mr. Barnard: I would say so, yes.

Ms. Hall: We would like to see, however, again, that people in the community who are familiar with it but do not have family in that home -- I'll be quite honest with you, people are terrified to speak up. They are terrified because there is no alternative for their family member. They cannot bring them home because they can't get enough support to look after them well at home and they don't know what they are going to do, and also they have, in many instances, no idea of their rights.

We find that administrators of nursing homes tell them the most ridiculous tales about what they must do in terms of having a home doctor, in terms of this, that and the other thing, and they believe that they must do these things. And it's very sad that the public is really terrorized by this kind of thing. And I would have residents in homes say, "I don't want to talk to you because we don't want you to cause any trouble here. It's not very good, but it's as good as we're going to get."

Mr. Cooke: We've had the same thing. I share your concerns about the residents' council, and I know that the committee is going to be looking for some solution to that problem. You've probably put it in a more forthright way than anyone else has about the concerns of residents' councils, but I share those concerns, that we don't want to put them in the position, or we don't want them to be a political buffer between what the inspection branch should be doing and holding the minister accountable for any lack of action that may occur or not occur in the nursing homes in this province.

Ms. Hall: And what they're going to be is a buffer.

Mr. Chairman: Mr. Callahan:

Mr. Callahan: Mrs. Hall, can I assume from your documentation, your research on these matters, that in some cases, if not many of them, a good deal of what goes on and is allowed to go on happens because the young people who are putting their elderly senior into a nursing home really don't pursue it, don't really look into it? They just want to house, really, the senior. Would you say that's a fair statement?

Ms. Hall: I don't know whether it's a fair statement. We have to ask ourselves why they want to house. I think they -- I think they do. I think that families today are unable to deal with what is happening to our old people, from the, first of all, from the physical standpoint and second from the mental standpoint. We are having people live well beyond the time when they used to live and in conditions which people are not really familiar with. And you see, there are some families that just want to warehouse their elders. There is no question about that.

But many families have no help to deal with the guilt that has built up from having to, really having to, not being able to care for

them at home, with the fact that they know the situation they are in is terrible but they don't know how to do anything with it. I have had people weep to me, say "We know it, but what can we do about it?"

Mr. Callahan: This is younger people?

Ms. Hall: Yes, these are younger people. On the whole, you will find, in our area, anyway, it's people my age. It's the middle-aged people that are having to see their parents or their aunts or their cousins go into these homes, and they have absolutely no help to deal with what is really a terrible family situation. How do you deal with a mother that can no longer speak and wets the bed and really doesn't have any knowledge of where she is? How do you yourself deal with this? And I feel sorry for families and I again say if we had a proper primary nurse in there, she would be educated to help families deal with this kind of thing.

Mr. Callahan: I guess what I'm really getting at is that if the loved one who's putting the loved one, hopefully the loved one, into the nursing home is not able to blow the whistle as it were, is that failure to blow the whistle because they just don't care; they want to wash their hands of the situation, or is it because there is no mechanism for them to blow the whistle on?

Ms. Hall: I think mostly there's no mechanism. There's a rare case where people just say good-bye, but it's very rare. And families are really terribly torn by what is happening to people.

Mr. Callahan: Well, it seems to me that we talk about our society improving and advancing and becoming wiser over the years, and really what we've done is we've moved from an historical dealing with seniors in the past, where they were kept at home and became the center of the family, really the educating tome of the family, and we've now moved towards, over the years, we've moved towards warehousing.

Steps have been taken, as you're probably aware, through our government in a number of areas to try and keep seniors at home as long as possible, things like family lots where you could have your parents live on the same lot you're in, more aid for home care to allow seniors to remain in their homes by providing assistance through services such as snow shoveling and lawn cutting and so on. So we have been moving in the last couple of years to try and change the plight of seniors and to address them more from the standpoint of human beings who should be able to live out their final years in dignity and only as a last resort be placed in these nursing homes.

Ms. Hall: Well, Mr. Callahan, you know, I think this machinery that has been put in place, mainly from Toronto, or from the bigger urban areas, but let me tell you, it doesn't work in the rural areas. You know, our geography and our climate is such that it's very difficult. You know, I get a bit disturbed when I hear, and I know -- I'm a 100 percent for people living in their own home as long as they can, but I certainly think we're always going to have to have good institutions.

And those institutions should be places, in my opinion, where people can come and go and don't do what they do in our nursing homes now. You take your relative in there and it's an entry into the funeral parlour. And so I really think we need to have proper, primary health care which looks after the total community and part of their interest is care of the elderly. And this we do not have in this country, and it's certainly -- these kinds of things certainly don't work in the rural areas.

Mr. Callahan: Well, I think I know what you're talking about because even though Brampton is no longer a rural area, it was at one time, and I think I understand where you're coming from in that regard.

Thank you very much, Mrs. Hall.

Mr. Chairman: Mr. McLean.

Mr. McLean: I want to thank you for taking part, from the heart, and you've touched on all the points in a short period of time, and I'm very moved by your presentation. And one thing that I appreciate about it, your whole theme was based on the resident and that is what my primary concern is, too. And you certainly touched on many issues, and I will look forward to reading the Hansard report when I get it. I liked your comments. I really haven't any questions, but I was just really thrilled with the presentation that you made.

Thank you.

Mr. Chairman: Mr. Cordiano.

Mr. Cordiano: Thank you, Mr. Chairman.

First of all, I just want to reflect a little bit on the question of residents' council. Yesterday we heard from the Ontario Coalition of Seniors Organizations, and what they seem to say, in fact what they clearly said was that the residents' council itself should have more, more of the powers that are now vested in the advisory committee.

What you seem to be saying today is that the elderly are deferred from some circles, that they're frail and they're weak and they're afraid to actually engage in the kind of thing we foresee for residents in the Residents' Council Act.

Now, give me an indication how you reconcile those two groups, and I'm not suggesting that you answer for the other group, just what your opinion of that? Do you think the residents' council should have more powers or, indeed, would it be fruitless to give them more powers?

Ms. Hall: I think it depends on the composition of the residents' council. If you have persons from the community who can speak out on that council -- and it is, as you know, there's ways of having your relative or your friend or so and so, but let me tell you about residents' councils that I've been to recently.

The two that I have seen recently are both organized by the staff of the home, in other words, the activity director in these homes, and very well done. I have no criticism of what these women did, but they sit still and hand the president the material. They -- if he doesn't know what to do, they tell him what to do. It's guided entirely by the staff. Now, there wasn't a resident in that home who could have done better than the person who was the chairman, an elderly gentleman, a delightful elderly gentleman, but at the end of the one council meeting -- and I really wish I had a tape -- the activity director went up to him and said, "Now, these things have to be signed, Mr. Chairman." And he said, "I don't understand what those people want me to do. I can't even sign my own checks anymore. I can't sign all these things." And I think this sums it up very well.

Now, there are some homes where there's a small group of residents, and again, you have a possibility of getting a tyranny by residents. I think the residents' council should be there; they should be made as effective as they can be; there should be a place where people can talk and ventilate, but I think they need assistance from outside people who have no vested interest in the home.

Mr. Chairman: Mr. Andrewes has a brief supplement.

Mr. Andrewes: Just to be fair, I think the group yesterday suggested, in fact I can read you exactly what they said, "the coalition recommends that residents' councils will be made up with a majority of residents from the home and whose role would be provided in support to the council and to be a watchdog over the nursing homes generally." That is what the coalition proposed, which was somewhat different from the act.

Ms. Hall: That's something we'd like to discuss because that's an alternative we didn't think of. I think there are some, some immediate dangers that one sees in it, in terms of, again, the residents can be very much influenced by the staff.

Mr. Cordiano: If I could just point out, in addition to the residents' council, you're aware that there's a three-tiered residents' council for members of the advisory committee and then there's the advisor and perhaps the advisory committee. But the advisor is -- I would say that the advisory committee is closer to what they were talking about yesterday. In fact, the act now provides for up to seven members of the residents' council to be on this advisory committee, and that in addition to that, you would have three members that are selected from the community at large.

Ms. Hall: And how selected, please?

Mr. Cordiano: Well, appointed by the minister. The three outside committee members would be appointed by the minister, from the community.

Ms. Hall: From the community.

Mr. Cordiano: So I suppose what we heard yesterday and what

Mr. Andrewes alluded to is the fact that the expanded version is something that the coalition would like to see in place. Now, I'm not so sure if that's the best way to go, but indeed, what you're saying is that the residents' council is largely made up of people that, well, for all intents and purposes, who direct their own course of action.

I don't like to think of it that way. I would like to think that the residents themselves would have the ability to have input into what's going on with their own lives, and I would foresee that as an essential point in any kind of structure that we build because I think that it will be very effective if we now have residents participating in how their destiny could be shaped.

Ms. Hall: We couldn't agree with you more. We believe the residents must participate. On the other hand, we don't see how these are going to be organized and got going. You know, there's no mechanism. How do you do this in a home where people are totally dependent? It's going to be largely the staff that does this.

Mr. Cordiano: Well, are there not residents' councils in most homes now that do do this? And in fact, what we would have is the creation of an advisory committee on top of what exists already, and that the make-up of that residents' council may change from time to time, obviously it will. But in addition to that, you would have the advisory committee which would be created out of this act and put in place, and you will have the third level of, the role of the advisor attached to the committee.

Ms. Hall: Well, we would hope it would work. We have grave doubts. I think that, I think that the people who have worked with us in our setting realize that these are extended care residents. They are residents who are there because they largely cannot manage in the community, and they have, many of them have very limited, both physical and some physical and mental, and many of them have social disabilities, that they're not able to speak out.

So that we feel we need to look very carefully at the residents' councils and how they will work.

Mr. Chairman: I'm sorry, Ms. Hart has a supplementary.

Mr. Cordiano: Fine.

Ms. Hart: Mrs. Hall, you said something in your answer that I would like to pursue a little bit. You said that the residents are pretty much governed by what the staff tell them or something like that. I don't mean to put words in your mouth. Would you see the staff participating on whatever you call it, the steering committee of the residents' council or the the advisory committee or the board of directors, whatever name you give it? Would you see staff participation in that or do you see that that's not a good thing?

Ms. Hall: There are many, many good staff members who really have the welfare of the residents in mind. These activity directors I am speaking about are excellent women. I think there is a place for

staff, but I think that the decision-making powers should rest totally with the councils and the people who are put in position to assist the councils. You're not going to have these meetings unless staff, unless somebody comes in and organizes. Now, most of those, many of those people have to be brought down from the wards to the meeting place. They have to be got out of bed. They have to be assisted. Without staff participation in this, just from those practical terms, these councils wouldn't happen, at least in the homes we know. Very few of the people we know are able to get themselves to the residents' councils.

Ms. Hart: In the organization of these meetings, would you see it as helpful in having a community person?

Ms. Hall: Oh, absolutely.

Ms. Hart: Even set up the meetings?

Ms. Hall: Absolutely. I think you need the community people in there. I think they're the ones that should be working with the residents to organize the meetings. The staff can take them down to the meeting and the staff may be there if they wish to be. It's very good for them to hear that, but I certainly think the organization and conduct of these meetings should be outside the responsibility of the staff.

Ms. Hart: Thank you.

Mr. Chairman: Mr. Callahan had a supplementary, also.

Mr. Callahan: On that vein, it's unfortunate that with all the power that we possess, we can't legislate understanding and caring and so on, so I guess what you're really looking at in these councils is someone to keep an eye on perhaps the abuses that have occurred in the past and perhaps the inactivities that have occurred in the past. And I suppose what you'd really want is someone who is not going to have a conflict, who is not going to be afraid to speak up because they're either a resident or so on.

I'm sure you're aware of the act that in setting up the council, it can be set up by either the residents or their representatives, which means that if, it sort of addresses what you said was lacking before, that if I had my mother there, and I see something going on that I don't particularly like, I suppose as a representative, I could move to get on a council or become a member or to set up a council. And I think through the other one that Mr. Cordiano referred to, the three members being appointed by the minister, in fact, the minister can control the sensitivity or insensitivity, if it's perceived, that's going on in that particular nursing home and may go a long way towards addressing the objectivity or the outsideness that's required to deal with those issues.

But do you see that as any comfort in terms of what you just related.

Ms. Richardson: May I speak?

Mr. Callahan: Yes, certainly.

Ms. Richardson: In that respect of the appointments, or whatever they are, of three people by the minister, as you say, so now where is he going to get his direction as to who those three people should be in the community? Is he going to perhaps be listening to the nursing home, the Nursing Home Association in the area?

Mr. Callahan: No, I would think the whole, although my colleagues in the opposition don't agree totally with it, I think they do see things here that will go a long way towards changing what existed in the past. Those efforts or those appointments would be made with a view towards ensuring or a view towards protecting the very purpose of the act, to look after elderly people in the framework of the opening statement, that the, it's to be considered as their home. I think that's the, clearly, the rationale behind the act.

Ms. Hall: I think, Mr. Callahan, that our members would be reassured that they had the criteria that the minister is going to use to select these people.

Mr. Callahan: Well, the minister would be as much bound by the nature of the act, and I can't find the opening portion, but it says something to the effect of recognizing the dignity of --

Ms. Hall: I have it here.

Mr. Callahan: -- the basic principles, that he would be as much bound by that in terms of finding people to fill that bill, and I would think that probably some input from local groups that would -- I mean, we all have an interest in it, I think even more great an interest as I get older. I would like to --

Ms. Hall: We all need to.

Mr. Callahan: I would like to prepare for that day when my children decide they've gotten their allowance long enough and it's no time to put dad in the home.

Mr. Chairman: And I hear that's imminent.

Mr. Callahan: Well, it could be. But I think we all have an interest --

Mr. Chairman: Caucus funds being designed as well, but that's another matter.

Mr. Callahan: But even quite apart from that, you're looking at, we're viewing charitable, not-for-profit nursing homes. We would probably have a different approach than, perhaps, the for-profit. But both of them have to be policed. That's a bad word but --

Ms. Hall: Monitored.

Mr. Callahan: Monitored, yes, that's a better word. And so I think that there are mechanisms in there that monitor, and, you know, I wonder if that gives you any feeling of assurance that there are steps being taken to bring an act together that will in fact make certain, as best we can --

Ms. Hall: Well, you can be sure that we'll try and make these things work, but we also will withhold judgments until we see whether they do work.

Mr. Callahan: And that's fair enough.

Ms. Richardson: And we'll be busy monitoring, too.

Mr. Cordiano: Just one final point. I want to make this somehow very clear, the fact that in my own mind, the residents' council and the possible weakening or ineffectiveness of that council, I think the effort in the act is being made to strengthen the council and what it can do because in fact what you have is a residents' council, composed of residents of the home, and an advisory committee, which is attached to the residents' council. That committee is to advise the residents' council. This is the way I'm reading it in the section of the act. It shall be established for each residents' council a residents' council advisory committee to be composed of as I alluded to earlier, and then attached to that advisory committee is an advisor.

And so all of these levels are designed to focus in on the residents' strength in their mind and the strength of the ability of the residents' council to perform, given the failings of some of these councils, and trying to beef up the support that they have. So I think it's --

Ms. Hall: I think undoubtedly if the residents learn that they can speak out without reprisals, you'll get a much better input. But right at the present moment, they're really quite terrified.

Mr. Cordiano: Thank you.

Ms. Richardson: And really in our local situation, we're sitting with, say, 89 extended care patients, and we would have a real chore, they would have a real chore at having 7 people that could do anything. I mean, they're in-bed patients almost type of thing.

Mr. Cordiano: In that case you would have to have representatives of each resident.

Ms. Richardson: Thank you. Just so you understand where we're coming from because there's no way we can look at it in any other pattern than they need help. They couldn't possibly run anything.

Mr. Chairman: Thank you. I have one other question, and Mr. Andrewes has one or several. This has to do with the appointment by the minister of more people out there in the system. There have been a

lot of complaints over the years about political appointments, whether they're paid or unpaid, and there are thousands of people who get appointments within the community based on their political affiliation more than anything else. This is a great and noble tradition throughout the country.

Do you have any concerns at all about another thousand, and that's what it would be just with our present nursing home stock, another thousand people being appointed by a minister rather than being developed within a community on their own?

Ms. Hall: I think this is what our membership is trying to say. It isn't that we mistrust the minister, but we think the mechanisms are open to so much abuse, if you like. We also think the people who live in that community and have their people in these homes and who are probably in a much better situation to know who would represent -- if the minister wants to make the appointment and can get a proper local list, a short list, if you like, fine, but we certainly think that these people should originate from the community.

Mr. Callahan: Well, they have to live in the area. That's part of it, no more than three members which live in the area where the nursing home is located will be appointed by the minister.

Mr. Chairman: The question I have is if you don't like the approach of the minister making the appointment because of the dangers of the politicization of this, what becomes the mechanism for getting good people from the local area? If you put it in the hands of the local municipality to make that decision, who ends up making the decision about who those appointments should be if it doesn't come back up to the central body of the minister?

We've had some suggestions that local women's groups, and I forget the mix that they suggested, local senior groups, women's group and church, was it? They want to have Church groups that the community sets up to be vested with this power. How would you see it being handled?

Ms. Hall: Is it not possible that the community could be asked to submit six or nine names to the minister from which he can choose, if you like, and it can be done in the way we do our hospital boards. In other words, people stand up and say, "I'm interested, I'm interested, this is a nonpaying position. I'm interested in this kind of thing, and this is what I have done with the elderly. Now please, would like to have your votes." And we get our six or our nine names from that community. And if people really want to change it, they come out to the meeting and change it. I know that from the hospital board setting, some of them don't bother to come out at all. You get into acclimation for 20 years, not quite but almost quite.

But this puts the responsibility back in the community, and it would give the minister a right to choose from between a list, six, nine, whatever you like. And if he wants to have their curriculum vitae, he can do so, as long as it doesn't have their political affiliation marked on there, also.

Mr. Chairman: Thank you, Mrs. Hall. Ms. Hart has a supplementary.

Ms. Hart: If I might pursue that a little. In fact, that's the very way that it's contemplated these thousand appointments will be filled. The problem with it is if you're not going to get any suggestions from the community -- there will be the odd circumstance when you don't. The section of the act restricts the minister to finding this group of people from within the community, and of course the best way is to get suggestions from the council, suggestions from the, all of the active groups in the community.

Mr. Chairman: The Riding Association.

Ms. Hart: I don't think that's fair. I don't think that --

Mr. Chairman: It's a tradition.

Mr. Callahan: That's not the way it's done.

Ms. Hart: But if you have any suggestions on how to do it in the community where you're not going to get names put forward, that is the difficulty that the minister has to deal with. I'd be interested in hearing that.

Ms. Hall: Well, then, I think you should get the neighbouring community that is successful to go over there and say, "Now look, this is a good system and how about getting together and doing something about it?"

Ms. Hart: We might have some difficulty in areas of this province where geography --

Ms. Hall: I think this is true, and I'm sure you're always going to have the people who default on it, but I would think the majority of communities would be glad to do this. Certainly, the areas around, that we're speaking of, would do it.

Ms. Richardson: Rural areas, that would be.

Ms. Hart: To give you some comfort, that's how the minister proposes to make these appointments. Is that fair?

Mr. Chairman: That's how it's spelled out in the legislation.

Ms. Hall: I think so.

Mr. Chairman: Mr. Andrewes.

Mr. Andrewes: Thank you, Mr. Chairman. My apologies for my late arrival.

The concept that was proposed in terms of the residents' council, of course, involves the community. I wonder how you feel then about

the concern that some groups have expressed about the minister's right to ask nursing homes to provide services into the community like Meals on Wheels, like other special services and so on. There have been a number of groups that come here and said that that is not the function of a nursing home. I guess my personal view is if we're trying to make nursing homes a part of that community, then in certain circumstances it's quite appropriate that they be delivering services to the community as well as to its own residents.

Ms. Hall: Well, I have a very strong feeling that I wish the minister would see that we got proper primary health care that would look after all of these things in some kind of centralized way, but in the meantime, while we're waiting for that to happen, my own personal feeling is that there's no harm in situations where -- for instance, the home that we're speaking of did have Meals on Wheels.

Ms. Richardson: Yes, and there were problems on that. It was another lady that was operating a lodge, they had the food come out of our day care appointment, but it got so -- they just went. They couldn't deliver what they were given, so --

Ms. Hall: Again, I think that this is a money-making thing with many of the homes, and I would be very sad if that's what it was used for, to bring extra money into the pockets of owners. But certainly, communities ought to be able to organize themselves in the best way possible to meet the needs of the people who live in that community. And if that means extending services from a nursing home, fine, but I don't think it's something that they should be required to do.

Mr. Andrewes: No, I'm not thinking of requiring them to do it. It's an option we shouldn't by way of these amendments eliminate.

The second, I was interested in your comments about nursing care. Perhaps you could elaborate a bit on the standards that concern you and then perhaps comment on the qualifications of the personnel who are currently in the, manning these positions. I'm a little concerned about the term manning, too.

Mr. Callahan: That's sexist.

Mr. Andrewes: And I think the other thing, I wouldn't mind if you comment on the training and subsequent retraining or enriching of that training that might occur for the staff of nursing homes.

Ms. Hall: Well, Mr. Chairman, perhaps I should say that I spent 26 years of my life as the advisor in nursing and midwifery to the World Health Organization, first in the regional office for Southeast Asia and second in the Copenhagen Office in Europe. And I came home five years ago to retire.

Now, let me tell you, I am appalled at the level of nursing care in these homes. I do not feel that the registered nurses have in any way met their responsibilities. I know many of them, and I know that many of them are very distressed by the situations in which they have

to work, but I can quite frankly say that I don't think they make as good use of the situation as they could, even when it's bad, and I am astounded at the expectations or lack of expectations of the Canadian public with reference to the registered nurse. Most of these nurses have absolutely no preparation in geriatric care.

Now, I believe that the care of older people in extended care such as this is a specialty. And I believe that there should be in each of those homes, or available to nurses in those homes, somebody who can advise them on how to deal with the nursing care situations which they meet in the homes.

I have spoken personally to the council and expressed my dismay at the quality of care which is offered. I have spoken at the Registered Nurses Association and told them that I don't think that they're meeting their responsibilities, and that personally I would encourage the citizenry of Ontario to rise up and tell them that they're not meeting their responsibilities. The numbers of registered nurses in those homes are so few that they can't possibly plan and supervise the implementation of care and evaluate the outcomes. It's not possible.

On the other hand, most of the nurses I see are sitting in the nursing stations. They are writing out their reports and they complain to me bitterly about the government reports that they have to fill out. They say that they occupy so much time that they really don't have time for nursing care, and I think somebody needs to look into it, because there's tons of paper going somewhere.

They give them medications in the homes, and again, the medications in the homes need somebody to look into them. It is atrocious what is being pushed down the throats of our elderly. Now, you know the British have proved that 56 percent of all their admissions to hospitals of older people is because of overdrugging. Well, the overdrugging, I suggest to you, in those homes, is very sad.

And those are the two things that I see registered nurses doing in the homes.

Now, the registered nursing assistants and the aides are doing the hands-on-care, and they are not qualified to do many of the things that they have to do. And I take my hat off to them because some of them are doing very good jobs. But I do believe that we have to lay down proper expectations of what the registered nurse will do in these homes, and it should be related to primary care and the use of the nursing process and the evaluation of the outcomes of care.

There is no evaluation of the outcomes of care. You can give laxatives to the patient for 40 years and nobody ever evaluates whether it's worked or not. They need to have available to them properly qualified people in gerontological nursing, and they're here in the province.

So that as far as I'm concerned, the nursing care in the homes is abysmal, and I would say that if you look at these homes in terms of

the Scandinavian homes, which I know very well, we should be ashamed at what we're offering our elderly.

Mr. Chairman: That cuts things off. It's been a fascinating exchange. I really appreciate your attendance and your forthright approach to imparting information that you have. It's great. It has everybody awake this morning, which is remarkable for a legislative committee, and we're delighted.

If you do get a chance as an organization to pull together a report for us on any of the additional matters coming out of some of your discussions with Mr. Cordiano or Mr. Callahan, for instance, any further thoughts on that, please send it along to us. It would be helpful and I'll make sure it gets to all the members.

Ms. Hall: Mr. Chairman, you may be interested to know that we're working with McMaster University and Georgian College at the present moment to try and prepare an assessment form which the average citizen who may be a resident in these homes or who is going to have a family member in these homes can use to assess the quality of care which is being provided.

Mr. Chairman: That's a very good idea. And your ideas on primary nursing care were very interesting, and Mr. Cooke's caveat about the limitations that we have in terms of the amendment are too bad. It would be interesting to see if we could take some initiatives in that area.

Ms. Hall: We appreciate the opportunity to meet with this group.

Ms. Richardson: Yes, we do.

Mr. Chairman: Ms. Hart has one further thing to say.

Ms. Hart: When you come up with that form, we would be delighted to see it.

Ms. Hall: We would be delighted to send it to you.

Mr. Chairman: Thank you very much again. Mrs. Richardson.

Ms. Richardson: We feel very fortunate about having the leadership that we do, you can bet. We are all very concerned, but we're all very common, ordinary people in a rural area.

Mr. Chairman: You have a dynamite meeting.

Ms. Richardson: You recognize the good. We appreciate that.

Mr. Chairman: Thank you, Mrs. Richardson.

Our next presenters are from the Council on Aging which is based in Ottawa, and I ask the representatives to come forward and take the seats that are already warmed up for you there.

Ms. Strachan: Thank you.

Mr. Chairman: The members have just been distributed your document so they haven't had a chance to go through it yet. It's as informative a document as I've seen now for the last 20 minutes or so.

Our method is such that please just introduce yourselves so Hansard has a clear idea of who is who and then proceed through your presentation any way you'd like, and then I'll open it up with questions from the members that follow.

Ms. Strachan: My name is Norma Strachan, and I'm the staff person. I'm the Education Coordinator for the Council on Aging, Conseil Sur Le Vieillissement. To my right is Barb Burns, who is on our Executive, at the Council on Aging, and Mr. Don Evans, who is also on our Executive of the Council on Aging.

Mr. Chairman: Proceed any way you'd like.

Ms. Strachan: What we would like to do is my opening it up with a little bit of introduction, and then I'll hand it over to Barb and then I'll do some overheads.

Mr. Chairman: Is Mr. Allen in your way? Should I shift him?

Ms. Strachan: I don't think so. I think we'll be okay.

Just as a method of familiarizing you with what we're all about, I'll just give you a little explanation about the Council on Aging because it's a different model from a lot of what happens in the rest of the country.

The Council on Aging in Ottawa-Carleton has been in place since 1975. We have a council, which is one group of about 40 people. We try to keep the membership at one-third older adults, one-third professionals, and one-third interested community members. And then coming down from that in the organizational structure, we have various standing committees. Like we have a committee on education; we have one on economics; we have one on health issues.

And then we have various subcommittees. For example, we have, pertaining to this, the community education subcommittee, and they have within the last few years taken it upon themselves to really look into long-term care in the Ottawa-Carleton area. They've produced various programs in concert with interested community groups. One has been involving families, to help families ease the transition if a family member has to be placed in a long-term care institution, what are the things that they should understand about the aging process, what should they understand about long-term care institutions and how do they work?

I mean just explaining to them about nursing homes versus homes for the aged is enough, but they also need to know a little bit about, it's not that you're taking your aging relative and that they're going to this long-term care institution and that that's the end, that there

should be kind of an interactive process with them from that point.

We've also developed something called the "Guide to Selecting the Long-Term Care Facility," and this guide gives people questions that they can use in trying to decide where should my aging relative be looking at locating themselves, what are the things that are important

In March of 1986, the community education subcommittee took on something called the "Long-Term Care Forum," called "Issues and Realities of Long-Term Care," and they produced a report. That's in the back of your yellow document that we just gave you. There were several recommendations that came out of that long-term care forum report that looked very closely at residents' councils. And when we saw this legislation coming up, the Council on Aging thought that they really should be very active in commenting on it, particularly pertaining to residents' councils.

We have done other things, or we have another committee set up right now looking at abuse of older adults. They're looking at community and institutional, all of the aspects of abuse, but their report won't be ready until the fall so we're not going to comment on abuse right now.

But we would like to talk with you about residents' councils, and to do that we have Barbara Burns who has done a lot of work with residents' councils. She's set up and worked with them. She's also been a family member who has looked at placing relatives, both her own family and her in-laws. She has a nursing background and she is working on her MSW, looking at specifically nursing homes.

So I'll hand it over to Barb and I'll try the overheads.

Ms. Burns: Oh, you changed.

Mr. Cordiano: It's temporary. I'll be chairman.

Ms. Burns: We really would like to thank you for this opportunity. We thought initially we would send you a paper proposal, but we are very pleased to be asked to come down in person. So we really appreciate this.

The Council on Aging is a planning body. We don't do practical hands-on work. We look at the quality of life of seniors, and because of that, this is why we looked at only 17, Section 17, in reference to the residents' councils. So really that is going to be the total focus of our presentation.

We feel that residents' councils serve two purposes. They function as a vehicle for the residents themselves to exercise their rights and protect their interests, and they're also a therapeutic tool for maintaining some self-control and for maintaining some of their autonomy.

I think one thing we have to be aware of in looking at this legislation, possibly, is how is it going to affect the years ahead?

The population of the elderly that are in nursing homes now, I think we may all, from what we were hearing before, we feel that there is a problem in this promoting and starting and carrying on with the residents' councils.

But I feel this legislation that you propose is going to be looking at a different aged cohort a few years down the road. You're going to be looking at people that are more familiar with that process, with that residents' council process. So I think this is one thing also that you should keep in mind.

We're going to look first at the membership of the residents' council, Section 17e, line 3. We interpret this to mean that the intent is to encourage each resident to participate in the operation of their residence, and if that person lacks the physical or the mental capability, to participate through somebody else, their legal representative, quote, unquote.

I'll say in the beginning we really don't agree with this, and the reason we don't agree with it is, basically, we think that you're taking away some of the powers of the residents themselves. We believe each resident is unique and that only that person can represent himself or herself. We think that by appointing, or whatever process you're going to put in, be it a legal representative, be it next of kin, be it power of attorney, we feel this is a somewhat maternalistic attitude. We realize that some residents, yes, as the lady previous described, are not able to communicate effectively. But we do feel that in this case, other residents could represent that person.

We feel that the, by opening it to non-residents, you're possibly opening up participation in a residents' council to a wide variety of interest groups. We feel that they never, that these non-residents don't share in the day-to-day experiences. I've visited nursing homes three times a week over a two-year period. I would have been, if this legislation had been in effect, I would have been a logical person to become one of the people possibly to assist with the residents' council, or to be on the residents' council.

But I honestly cannot, could not feel how the residents themselves felt. I could not really be aware of what my mother and my dad, and they were in simultaneously in one nursing home, how they felt. I could really not myself be their representative, but yet I was visiting far more frequently than another person.

And the other thing too is that we feel the residents' council could possibly be taken over by special interest groups or people with special axes to bear, or perhaps a young energetic person that is just a natural born leader and could just take over anything. We don't feel that this represents validly the residents in attitude or in approach to their problems.

We do have one or two solutions which we will get to later on. We feel that the representation on the residents' council could come from within the residence building itself. In one nursing home in Ottawa-Carleton, a large one, they have got representatives appointed

from the, let's call them the well floors, to the frail floors, and one -- I'm not sure how this division is made, but one person, for example, will have a floor, one of the residents themselves who is well and able to function and speak quite well takes it on as part of his/her concern to see how the residents are doing on the frail floors where they're not being represented. It seems to work, from the staff impression anyway, that it seems to work.

We also recognize the need in a nursing home for families, but feel that the family's needs could be more strongly represented through a family group. Certainly in homes for the aged in Ottawa, this has now been started. It's taken a long time to start, but they have certain interests and it is for the families of the residents.

So, just in conclusion here, we feel, the Council on Aging recommends that residents' councils be composed solely of residents and that family councils be established to deal with issues of concern to the families.

The next one we wanted to look at was the advisory committee. Our interpretation is that there appear to be two objectives, to increase public accountability and to strengthen the residents' council by bolstering their autonomy and decision-making powers.

It appears that in an effort to satisfy the need for public accountability, a body is being established that will create more problems than it will solve since it has got two conflicting objectives. You've got the one objective of monitoring for value and you've got the other one of strengthening the residents' council, and what we're concerned about is we think it's going to set up an adversarial position within the residents' home. Above all, we have got to remember that this is their home. Residence is so often used, and in fact, we should be concentrating more on the word home.

We think that by providing this power to this proposed advisory committee to review allocation of money for food, et cetera, we think that you could almost set up two opposing camps, one in sort of a combatant environment towards the other. And my real concern is that if this is set up in a nursing home, you're going to produce increased stress, and if I had the time to figure out one definition that describes aging or the elderly, it's the reduced capability to respond to stress. It can be physical stress, but it also can be emotional stress, and we think this situation might be created.

We feel that this advisory committee should be primarily educated, educative, and we think it should be heavily weighted in competition to the elderly. It should advise about residents' councils. We've just dreamed up a structure because in Ottawa-Carleton we have a situation, unlike the previous group, we have got ten nursing homes, nine for profit and one private, nonprofit, the newest one entering into the field. And this is both in Ottawa and Carleton and outside.

We find it hard with your description of how you would appoint the members to these advisory committees that you're proposing. We

find in Ottawa-Carleton, this would really be difficult. For example, of those ten nursing homes, four of them are in the west end of the city. Does this mean that there is going to be a committee per west end nursing home with this advisory group, three of whom are going to be selected geographically? It would make it very hard.

We feel that perhaps you should maybe look at it more from a community aspect. If it is modeled perhaps somewhat on the District Health Council, but we feel that a regional community board should be appointed, and we haven't yet gone into the exact process. We're using the word appointment, perhaps, in quotes. We feel that it could be made up of residents, excuse me, of representatives, obviously, from the residents' council. We think it also could be drawn from families, from religious groups, from professional groups. Why not the Association of the Residents' Councils of Ontario, staff groups, special interest groups, perhaps people from the nursing home inspection branch.

If you have questions, perhaps we could come back to them because we have one more comment in regard to the council advisor. Now, as we understand it, this is going to be a ministerial appointment to support the residents' council advisory committee and this person would have free access to any information regarding nursing home management.

We're wondering why this was not, this position was not included with the nursing home branch, rather that they're stretched. But if you're going to be appointing, and again we don't know what mechanism you're going to use, if you're going to be appointing these people and it seems to read that there's going to be one per advisory committee, does that mean there's going to be a salary? Does that mean it's going to be a ministerial appointment? These are some of the questions.

But one of the questions we have was why not include this in the nursing home inspection branch. We feel again that by putting in an advisor in this capacity, as described in the legislation, we feel again that this is a disruptive role and we feel that this adversarial condition would evolve.

We do have a suggestion, and as I listened to the lady beforehand, I thought, I'm getting more and more convinced that this would be one way of solving. This diagram is also in the last page, the Appendix B of our report.

If you look at that, we've got family groups and we've got a residents' council on the left-hand side. In the middle, we've got the advisor. We think that this would be more, would be a better way of looking at it, and this advisor -- in Ottawa-Carleton, for example, with ten nursing homes, we think that the work load would be one and a half staff people. We think that they could be attached with the nursing home branch in the sense that they would have an office there. But we think that the advisor would enhance your residents' councils.

You know, as we dreamed about this, we could see this advisor coming in, possibly, with a good background in gerontology, geriatrics, but also in group work skills, that could work with the residents'

councils, could arrange meetings of residents' councils, one with another, could arrange meetings with the presidents of residents' councils in perhaps one section of our city. This would possibly be ministerial appointment which would keep them free of the administrator, so that they would report to administration but they would be responsible to the residents' councils primarily.

We think that there's a lot of validity in what we're saying because what you're trying to do with residents' councils, are you in fact improving and enhancing them through giving the powers to them to look through the books?

As I said at the very beginning, the Council on Aging is interested in quality of care. We are not approaching this from the standpoint of accountability. We are just trying to enhance the residents' councils.

I have worked with two in a higher level of care. One was a higher level of care; one was a comparative level of care. And I well recognize the many problems that, for example, the lady before us was talking about, but I think really perhaps that you're downplaying the potential of the residents to develop a residents' council with an advisor, perhaps with an advisor to help them, to help them with their agenda, and not a staff person.

And I agree with what she said about the activities person. They are not trained in helping residents' councils. They do tend to dominate. They in fact have prepared the agenda; they probably type out the newsletter, and they take the recommendations to administration. But by creating a position like this, away from administration, and again looking at education and informing, we feel that it could be really quite productive. In fact, we don't know why you haven't thought of this before. It seemed so obvious to us at one point.

Anyway, I would just like to thank you for your time in allowing us to present this and if there are any questions --

Mr. Chairman: Thank you. There always are. One of the other reasons why you have come up with the formula you've come up with is take away from some of the roles which are being given in the proposed amendments to the advisor and to the advisory committee, which are investigatory and that kind of thing?

Ms. Burns: Um, hm.

Mr. Chairman: And you see that more properly with the inspections branch people. You didn't talk about that very much; you talked about not wanting to get into the sort of structure that would develop conflict automatically. Is that what you are getting at?

Ms. Burns: Yes, this seems to -- we talked to people who have worked in the nursing home branch. In fact, one of the coordinators with Norma is a past nursing home inspector. We talked to her about this situation. She said that given clear criteria, she feels that it

could be developed. It would not, should not be a nursing home inspector, though. It should be a special created position.

Now, the accountability part would have to widen the broad lines, the guidelines for the nursing home inspectors. Quality of care cannot be legislated, and I realize this is basically what you're trying to get at. How in fact do you legislate that tender nursing that so many staff are performing daily in our nursing homes? If the legislation included more compulsory staffing regulations, perhaps this would help also.

As I understand, particularly the profit-making nursing homes are following these guidelines fairly strictly, but if it was legislated that there had to be more staff on, I would think that this might solve part of your concerns.

Mr. Chairman: I'm going to turn this to the members who are on the list, but first, when you talked about these various, your way of thinking of this, which I find quite attractive on first seeing it, you don't deal at all with functions, particularly. You do, but mostly as a sort of assistant to the committees, the council in terms of processing and understanding how things work and that kind of thing, and you want these kinds of skills.

17e, Sub 2, it defines the functions of the advisory committee, which you're now turning into a regional style committee under your mechanism. Do those kinds of things still hold as things that you would see as part of that committee's mandate under your new formula? Just to show you what I'm getting to, for instance, 2c, to receive and investigate complaints from residents and other persons and to mediate and resolve any dispute between a resident and a licensee, et cetera. Are those -- I have essentially alluded to a very different kind of notion, but you didn't specifically deal with that in your remarks.

Ms. Strachan: Yes, you're correct in what you're thinking. What we would rather see is that the regional committee functions more on an advisory level, as its name indicates, and rather than being -- when we read this section, too, it sounds like this committee has a lot of power to do things that we think the nursing homes inspection branch is looking at more closely. And if it's regulatory, then we think it belongs over there and that it doesn't belong with an advisory committee. We feel that an advisory committee should be here to educate.

And I guess we see kind of a more positive model than we see coming out of this legislation. This sounds kind of negative and authoritative to us. We don't care for that.

Mr. Chairman: Mr. Cordiano.

Mr. Cordiano: On the same theme, thank you, Mr. Chairman. I just want to get a couple of things straight, particularly with your comments as to the adversarial nature of the various levels, starting with the advisory committee and then the role of the advisor.

Looking at this Section 17d, Subsection 2, it is not only the role of the committee to investigate and have some authority over some of the matters that deal with the residents. It's not just an investigative body, as I read it, because Subsection a, "advise residents respecting their rights and obligations under this act; b, advise residents with respect to obligations regarding licensee under this act."

There is that kind of role that you're speaking about, for the advisory committee to play that kind of role as a positive educative body, and I don't perceive this body just acting as an inspection or division of the inspections branch. I think, however, just because you have access to documents and access to information, that that not necessarily leads to acting as an unwieldy body that's authoritative in nature and that tends to become simply an investigative body. I think that we have to have access to information in order for residents to have some investigative, some way of controlling their own destinies in the nursing home.

And I think that's what this attempts to do is to give them an opportunity to see how the home is run and to have a better notion of how monies are spent and if there are complaints, indeed, to look into these complaints, the very nature of those complaints.

I don't think it's the, I don't think it's the intent of this section to create a body that's adversarial in nature. Of course, that's my opinion, and I'm putting that forth for discussion.

Ms. Burns: Don't you think, though, that the atmosphere is going to become somewhat adversarial? I mean, if you try and think what it would be possibly like. You have given them fairly heavy functions, and they're going to take this on and they're going to perform it, and isn't it possible that it's going to separate them into a them and us type situation?

Mr. Cordiano: Them, meaning who?

Ms. Burns: The nursing home operators and the committee itself, which will mean that the residents are also included.

Mr. Cordiano: But is it not fair to say that at the present time, at the present time, the residents' council, the residents and the nursing home operators, there is a kind of adversarial environment or climate that exists?

Ms. Burns: No, I wouldn't -- certainly, you know, how do we --

Mr. Cordiano: It's one of, actually what we've heard and what I've heard, from my own personal impressions, is one of the residents' fear.

Ms. Burns: Are they fearing the administrator or are they fearing the staff person first and then the administrator?

Mr. Cordiano: Well, what we've heard is that residents in the home where the majority are weak and frail and are indeed in a fearful position because they're afraid that this is the best they can get and indeed --

Ms. Burns: And indeed they might be moved on, yes.

Mr. Cordiano: Exactly. So the point here is that it's not a question of a number of these residents standing up for their rights. They simply can't. They're not able to.

Ms. Burns: But where in that, in that situation, have you included that?

Mr. Cordiano: Where have we included what, I'm sorry?

Ms. Burns: The rights, because you're talking about the rights of the committee?

Mr. Cordiano: No, there is a statement of rights, or of principles, rather, which is in Section 2 of the act, but I didn't want to get into that because I am sure that you can look at that and I can look at that and we can have a great deal of discussion on that. But I wanted to focus in on the role of the advisory committee.

Ms. Burns: I think possibly it comes down to perhaps the way we feel at the Council on Aging, and I think this is that we are constantly stressing quality. And I think, you know when you raise your kids, you know that if you raise them in an atmosphere of criticism, you know, if you never praise them and you never say, "Hey, you're doing a good job," if you raise them constantly in an atmosphere of criticism, we know they're not going to grow and they're not going to develop. And we think it's almost the same with nursing homes. We feel that if we're constantly criticizing and not putting in something, that there is this potential problem.

Mr. Cordiano: Well, there is a useful purpose for members of the community to play in terms of supplementing an offer of support to residents of the nursing home, and in fact, the way the nursing home is run. And I think that's what Section 17e, with the creation of a residents' advisory committee, attempts to do, in having community members participate in that function and opening up the nursing home to the community and trying to reach out to the community and have active participation by community members. I think that serves that kind of a role.

Mr. Evans: Why do you need to give them all those powers then, investigative powers, if it's going to be a community, a volunteer effort of a person to do that? Why do they need all these powers that are going to generate the adversarial --

Mr. Cordiano: Well, it comes as a result of a number of your -- sir?

Mr. Davis: I just want to hear you defend it.

Mr. Cordiano: I thought you said something constructive.

Mr. Davis: I never say anything constructive.

Mr. Callahan: He just spoke up, Joe. When will you learn?

Mr. Chairman: These men are just acting out now through their middle age, and we don't need to have too many more examples of that.

First Mr. Cordiano, and then I have a supplementary from the member.

Mr. Cordiano: I'll defer at this point.

Mr. Chairman: You mean you're not going to ask any more questions?

Mr. Cordiano: I would like to, but I keep getting these supplementaries which --

Mr. Chairman: No, I said first Mr. Cordiano, and then we'll take a supplementary.

Mr. Cordiano: Oh, okay, fine. I just want to note, the purpose of having some investigative board for this committee, I think it's the intention for this body to look into the matters that the residents' councils were unable to look into, and in fact, they may have tried to look into but it was nothing that was effectively done over the years.

And I think that the role of the committee and the role of the advisor is to try and strengthen that investigative power and to try to give some measure of authority over that kind of thing, but in looking into a number of matters which Section 17e Sub 2 points out, then you're going to have some results. You're going to have some people looking into some very serious problems that occur in nursing homes.

And if you don't have that, then how are we ever going to know a better light -- I mean, we're still going to have to refer, some of these things will have to be referred to the inspection branch to have enforcement take place, and that's not the role of this advisory committee as we see it. The enforcement mechanism is still going to be in place as a result of the investigation branch doing their work.

Ms. Strachan: Even if you -- the intent of this is not that they would be predominantly regulative. If they still have this power and they uncover lots of interesting material about the operation of the nursing home, where does it get them? That's one of my major concerns, I would say. So I know how much money is being spent on food, and I guess when I'm saying this, I'm trying to speak from the voice of the Council on Aging, seeing that we represent both profit and nonprofit nursing homes.

And if this information is out there, well, that's nice, but then what happens? Does it not make it a little bit adversarial? Because

now I know what's happening and I know how much money is being spent on my food, but maybe I don't know that because this nursing home, let's say, belongs to a chain, that they have better purchasing power and that my cost for feeding this person is going to be less than it might be in another place. So when I look as a resident at the total cost, the total amount of money that's being spent on food per day, it looks terrible, but they don't always know the other part of it because maybe they are only going to be fed selective information.

Mr. Cordiano: Well, I would suggest that the operator would attempt to work with the advisory committees in fulfilling their part of the role, and that is to facilitate the role, the work of the committee and to enhance the image of the nursing home. And I don't think that there would be anything to hide at that point.

If you're making available all of this information, I cannot see how this cannot benefit the entire process by opening it up to the community, and this is why you have members of the community to be on this advisory board, to add their input into the whole process. But anyway, I'll defer to Ms. Hart.

Mr. Chairman: In this running debate, we'll no doubt be able to work in your response. But let's go now to Ms. Hart.

Ms. Hart: Thank you.

Mr. Cordiano has covered some of my concerns, but what I wanted to ask you, from what you've been saying, is it better not to know? My -- and I'll just follow up a little bit on that. My view of this section is that it merely empowers the residents, the committee, should it wish, to have access to this information so it can perform its educational function.

How is it going to perform in that function without the information? That's my concern. Could I have your comments on that?

Ms. Burns: Really, you really are just looking at accountability. I hadn't quite realized that until I got here today. That is the prime issue in this legislation, and ours is not.

If you really look at that, about the long-term care forum, which I wish you would if you have a chance because we've got an excellent letter from the Minister of Health in reference to it, this is a community getting together four groups, of families, staff, residents themselves. We had them brought in by Paramed. And I can't remember the other group.

But we met for a day and a half on long-term care, and this is essentially where we're coming from. We are not coming from accountability, and I say to you again that if you're going to, if this is what the legislation is for, then you're not thinking of the residents totally, you're thinking of the accountability aspect of it. That's my own personal opinion, excuse me.

Mr. Chairman: Ms. Strachan.

Ms. Strachan: We think the information should be available, and I believe in an open, kind of trusting system. Can that not be provided through a telephone call to the Ministry of Health? I mean, if we want to know the allocation of dollars, surely if the ministry is giving dollars to Nursing Home X in the community, they must need some kind of accountability system for how those dollars are being disbursed.

Mr. Cooke: No, not now they don't.

Ms. Hart: Well, following this legislation, there will be financial -- if it passes in the form that it's in now. There will be financial statements, presumably, that are filed.

So can I, can I take it from what you're saying that you don't want the residents' councils to be involved at all in the assessment of the quality of care in terms of is enough money being spent on food, are there enough recreational activities, that kind of thing?

Ms. Burns: What we're saying is that we don't think that the council should be made up of anyone except residents, that that's probably where we differ, and we --

Mr. Cordiano: You mean the residents' council?

Ms. Burns: The residents' council should be made up of residents.

Ms. Hart: Sorry, that was a slip of wording on my part. The advisory committee, you don't want them to be involved at all in looking at how the individual homes operate and in assessing the quality of care? I'm not talking about accountability to the minister but accountability to the residents, because after all their money is in there, too.

Ms. Burns: I know what you're getting at, and I don't think we're saying no to that. We're saying that we think that the structure should be different. We think that the role of -- where, instead of these small committees, advisory committee per nursing home, we're looking at it from the aspect of the community. And in Ottawa-Carleton we are fortunate we can do this because we have got ten nursing homes. It would stand to reason that we could have a community advisory board for the nursing homes.

And apart from the, from the educate role, we haven't developed the functions of it, which is essentially what you're asking.

Ms. Hart: I guess what I'm asking is how, how is this committee going to perform any functions without access to information? And giving them the power to have the information is a prerequisite to that, and that's what I'm asking you to consider.

Mr. Chairman: Ms. Strachan.

Ms. Strachan: Maybe that's fair game, if you look at this committee being a regional body, and I'm not saying a powerless regional body but a regional body. I guess one of our concerns is that if you have one advisory committee for each nursing home, it's even more adversarial than if you had, potentially adversarial, than if you had one regional body that looks after several, looks after, advises several. And then you don't have as much emotion getting involved in this nursing home and its residents and we're looking after them. If you take it away a little bit, give it a little bit of distance, then maybe having those powers is fine.

Ms. Hart: Thank you.

Mr. Chairman: Mr. Andrewes.

Mr. Andrewes: Mr. Cooke has a supplementary.

Mr. Chairman: Is this supplementary or --

Mr. Cooke: Yes, it was.

Mr. Chairman: Because all these questions are on residents' councils.

Mr. Cooke: I was going to take the one aspect of the financial accountability. I wouldn't disagree that the major, at least from my perspective, the major purpose of that one section is accountability, but I just wanted to make sure you understood. You said maybe residents can get on the phone to the ministry and get that information. None of that information is currently available. There is no one at this point who keeps any records. There is no requirement for submission of a budget or how money is spent in nursing homes presently. None of that is currently in the system.

Ms. Strachan: Thank you for that information.

Mr. Chairman: Mr. Andrewes.

Mr. Andrewes: Thank you, Mr. Chairman.

Needless to say, there are differences within the committee on the whole role of the residents' council, the residents' council advisory committee and the residents' council advisor, and I for one share many of the concerns that you've mentioned, in particular, the whole question of the adversarial and potentially adversarial role.

My own personal view is that it's an advocacy of the responsibilities by the minister over to a body that I'm not sure is in a position to do very much, based on the legislation, to do very much about the expectation that this legislation creates for it. It's not in a position to enforce all its findings. It's not, it's only in a position to carry out a very extensive investigation, to report then to the minister its findings and then the minister asks, I assume, through the director or the inspector, to go in and verify that. It seems to me totally redundant and places the residents' council and their role

such as settling disputes, minor disputes, in real jeopardy. So I wholeheartedly agree with your position.

I want to go now to some of the other things you mentioned. One was the question of the residents' advisor, the residents' council advisor, and your concept of the residents' council, that it would be a regional body and that the residents' council advisor would be able to provide to that body certain information and direction.

Are you suggesting that the residents' council advisor be an employee of the committee, of the regional committee?

Ms. Burns: That's not quite -- we felt that the role of advisor would be a provincial appointment to a region, to assist the residents' councils, not the advisory committee. We were bypassing that step. Since you're talking residents' council, since you're trying to talk, since you're talking enhancing residents' councils, I think a lot of people will agree that another staff person would help, we felt it would be better to create this position outside of the nursing home itself so that there would be no involvement with the administrator of the nursing home.

So again, we're just looking at, in Ottawa-Carleton, as we said for the one and a half staff people in our whole area to advise on the residents' councils.

Mr. Evans: Plural.

Mr. Andrewes: The proposal that we heard from the ministry was that this group of residents, residents' advisors, as you put the emphasis on residents' council advisors, would be independently funded, would be independent from the ministry, and for all intents and purposes, in the basis of my judgment, would be adequate. Is that your idea?

Ms. Burns: Some of it -- we were having problems with interpretation of the act. We didn't know if it was meant that it would be civil servants, or if it would just be a once-designated position. We also didn't understand where you were going to get the representatives on these advisory committees. I mean, for example, in Ottawa-Carleton, four in the west end, five in the west end, are you going to have one advisory committee per building, with one advisor, advisors, advising committee.

Mr. Andrewes: No, I think to be fair that the concept was yes, one advisory committee per building but one advisor for a region and area.

Ms. Burns: Thank you, we were unclear about that. We didn't realize that. Thank you.

Mr. Andrewes: We think that's the interpretation.

Mr. Cooke: We think.

Mr. Andrewes: We think. That's the interpretation we're hearing.

The other concern, I must say that it hasn't been raised with us before but I think perhaps it deserves some further comment from you, is the risk that community appointed or people appointed from the community could carry with them strong bias to a committee, the risk that a residents' council advisory committee or in fact, as some other groups had proposed, a residents' council which carries with it community representation, could become the sort of forum on which people with strong interests would raise their issue and would be able to grind their axe, so to speak, I think deserves a little more comment on.

Ms. Burns: Go ahead.

Mr. Evans: One thing that we've been very fortunate out in Ottawa, Ottawa-Carleton, and with our own Council on Aging, is being able to create a number of people, both seniors and otherwise, interested and volunteers in the group that enlists, and certainly on the appointee of this thing, as the Council on Aging, and me as a senior in the City of Ottawa, I want my name, or I want my effort to, in an effort to be able to select that person that's going to be there. And I think that on that basis, then we would be able to accomplish what you people really want to do.

I must, talking as a senior and one probably that's got one leg in one of these homes, eventually I'll have to probably go into one, but I think, I generally try to commend what you're trying to get in these acts, of getting the public to participate in the feeling or in the atmosphere and the living conditions of seniors. And possibly by bringing a representative in that could objectively judge how the home is operating, you would be able to get earlier knowledge of some of the horror stories that we've heard in the newspapers lately of homes generating like that.

From the Council on Aging, we certainly want to be able to, in the Ottawa-Carleton area, to participate in the selection of the people that are going to be involved in this, and we certainly would assure them of our every direction of this body that we could educate them into the way we want their advice to become popular and good for the home.

Ms. Burns: Actually, you just reminded me that when we first looked at this, when we first became aware that, of the amendments to the nursing home legislation, that was the first thing we thought of, was if there were going to be community committees or set-ups, representations, that we as a council on aging would really like to be able to prepare a list to have available for whoever is doing the appointment of people who we think would be appropriate to sit on these committees, people with some interest, some expertise, seniors where possible. I think what Don is saying, albeit one foot in the nursing home, that we all are potential candidates for a nursing home. I don't think that having a 20 year old sitting on a committee is truly representative of the feelings of some of us that are starting to

approach aging.

But that was the very first beginning of this more intense look at the legislation, and in Ottawa-Carleton we would really like to have some input to the make-up of those committees.

Mr. Andrewes: Can I just have one final kick at the can here with respect to the residents' councils. If you look under 17e(2), it says the function of the committee, and for all intents and purposes here, and I say the function of the council, "the residents' council, to advise residents respecting the duties and obligations under this act?" Is that okay?

Ms. Strachan: Um, hm.

Mr. Andrewes: "To advise residents respecting the rights and obligations of the licensee under this act." Is that an appropriate item for the council?

Ms. Strachan: Yes.

Mr. Andrewes: I don't think c is. I don't know what your comments are on c.

Ms. Burns: Well, again, I guess we get back to -- yes, we see this as a complaints committee. We don't see it as being a constructive --

Mr. Andrewes: Let's go to d then, and can I have your views on the four sections in d, how appropriate those activities might be for the residents' council, considering the fact that you're proposing that they be an advisor to the residents' council?

Ms. Burns: Can we just clarify? You're asking if we believe that the functions of the residents' council? This is made up of residents?

Mr. Andrewes: Yes.

Ms. Burns: Now, we're looking at it as residents solely, not being non-resident representatives. You're asking if the functions of this residents' council should include d(1) through (4)?

Mr. Andrewes: Right.

Ms. Burns: I don't know.

Mr. Andrewes: Maybe you could get back to us on that.

Mr. Cooke: Could I ask that you specifically, when you're getting back to us on that, look at the first line which says, "meet regularly with the licensee," and then I wouldn't necessarily see there's anything wrong with the reviewing of those things, but I'm not sure it's a good role to meet with the licensee to discuss those.

Ms. Burns: That's what brings in the fear aspect that the gentleman over here was referring to, that a situation like that could become fear producing, which certainly exists. We're not denying that at all.

Mr. Andrewes: What about e, "an attempt to mediate and resolve disputes between the resident and the licensee?"

Ms. Burns: It's an ombudsman role. We feel that that's apart from the residents' council.

Mr. Andrewes: As to the members reporting to the minister?

Ms. Burns: Well, I think that should be done just automatically. I think that they should all have the right to report concerns to the ministry.

Mr. Andrewes: Thank you very much.

Mr. Allen: Mr. Callahan.

Mr. Callahan: Just very quickly, I see what you're saying about the separation of the residents' council advisor from the residents' council, but in a very real sense, if you eliminated that completely and went to the inspection situation, inspectors might come into a home and residents would be scared silly about telling them about something, and if they did tell them something, they might say, "Well, they're just senile and we'll ignore that," you know.

I think that's the real beauty of having more sets of eyes than we've had in the past is that these people are on the scene, and it makes both people sit up and act honestly, the operators as well as the residents, in that each one knows that there are these powers available to them to avoid what we'd all like to avoid. In the unreal world, we'd like to be able to legislate sensitivity for seniors and caring, but we can't do that, so the next best step is to ensure that everybody knows that there are a lot of eyes keeping an eye on what is going on. That's the first thing.

The second thing is you talked about an adversary system, and I'd like to ask you a question because it was brought up by some other groups we had who believe that rather than having, as we've had in the act, a list under 1a(1) through (10), is that there should be, rather than just a listing of the objectives, that there should in fact be a mechanism to enforce a bill of rights.

Now, recognizing what you said about the adversarial problems, I'd like your comments, if any, on that, as to whether or not you're satisfied with the principles of the act as spelled out or whether you feel there should be a mechanism to enforce those rights, either through a board or access to the courts or whatever? Or do you see that as falling within the framework of your concern about being adversarial?

Mr. Cooke: But there is no bill of rights in the current

proposal.

Mr. Cordiano: But there's a statement of principles.

Mr. Callahan: But there's a statement of principles is what I'm getting at, David, and I think all in all you can appreciate that.

Mr. Cooke: There's quite a difference between that and a bill of rights.

Mr. Callahan: I realize that. A bill of rights gives people rights and the statement of principle says what the purpose of the legislation is. But that's not really my question. You're concerned about the adversarial issue. If we go the route suggested by some of the groups, the bill of rights, which is enforceable, do you see concern there in terms of the adversarial process?

Ms. Burns: This is new to us. We hadn't thought of it that way. I know we have looked at the fifth point, "each resident shall have the opportunity to participate fully in making a decision and in obtaining an independent medical opinion." We did feel that that could be broadened to go beyond medical opinion, that there should be an additional clause somewhere in there about respecting their autonomy. "Each resident will be treated with dignity, curtesy, and respect" is not as inclusive as we would like to make it, but we have not discussed what you're asking.

Mr. Callahan: Well, you might want to consider that because there have been very strong representations made to us, that, as Mr. Cooke said, that rather than a statement of principles, which is really what that is --

Mr. Cooke: An addition.

Mr. Callahan: I'm sorry?

Mr. Cooke: The proposal that we have from the groups is that we have in the bill a statement of principles that outlines how the act should be interpreted, and then in addition, we should have a bill of rights.

Mr. Callahan: I thought it was in place of that. But in any event, what I'm asking about is that these rights be enshrined in a way that you could enforce these rights, and I'm concerned because your comments about the adversarial side of it do disrupt, I'm sure would disrupt a nursing home. Let's say someone, those rights were in there and this person took those rights as enshrined in the legislation and was looked upon for the rest of their stay in the nursing home as being a troublemaker or someone to be shunned or avoided.

I think that's something that should be looked at very closely. Since you've not considered it, you know, it's unfair to ask you, but maybe if you consider that, we would certainly appreciate the benefit of your thoughts on that after you've had an opportunity to do that.

Mr. Cordiano: Any further questions? If not, then I would like to -- I'm sorry, did you --

Mr. Evans: I just wanted to, on behalf of the Council on Aging, thank you for the invitation down here today and listening to our views.

Mr. Callahan: Thank you.

Mr. Evans: We've come down here and I hope that we can keep feeding you information.

Ms. Strachan: As a staff person, how quickly would you like the responses to these because I'm thinking if you're meeting, I know the final submission date is February 27th, and being that we really believe in the community process, to try and get something together for the 27th might be a little tricky.

Mr. Cordiano: Well, I would say as soon as you could possibly do that.

Mr. Cooke: We do start clause by clause next week.

Mr. Cordiano: So if you could get it in by then. But on behalf of all the committee members, I would like to thank you for making your presentation.

Mr. Callahan: Particularly those of us who are getting older.

Mr. Cordiano: It certainly shed a lot of light on a number of interesting points. We've had an interesting discussion and I would like to pursue some of those further with you at some other date, and if you could provide us with that information, I'm sure it will assist the members of the committee.

Thank you.

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STANDING COMMITTEE ON SOCIAL DEVELOPMENT

NURSING HOMES AMENDMENT ACT

HEALTH FACILITIES SPECIAL ORDERS AMENDMENT ACT

TUESDAY, FEBRUARY 24, 1987

Afternoon Sitting



STANDING COMMITTEE ON SOCIAL DEVELOPMENT

CHAIRMAN: Johnston, R. F. (Scarborough West NDP)

VICE-CHAIRMAN: Allen, R. (Hamilton West NDP)

Andrewes, P. W. (Lincoln PC)

Baetz, R. C. (Ottawa West PC)

Callahan, R. V. (Brampton L)

Cooke, D. S. (Windsor-Riverside NDP)

Cordiano, J. (Downsview L)

Cousens, W. D. (York Centre PC)

Hart, C. E. (York East L)

Jackson, C. (Burlington South PC)

Reycraft, D. R. (Middlesex L)

Substitutions:

Davis, W. C. (Scarborough Centre PC) for Mr. Cousens

McLean, A. K. (Simcoe East PC) for Mr. Baetz

Clerk: Carrozza, F.

Witnesses:

From the Ministry of Health:

Hart, C. E., Parliamentary Assistant to the Minister of Health
(York East L)

Sapsford, R. T., Director, Nursing Homes Branch

From the Ontario Coalition for Nursing Home Reform:

Steffler, V., Chairman

Wahl, J. A., Legal Counsel; with Advocacy Centre for the Elderly

Robson, R., Member, Executive Committee

From the Ontario Association of Residents' Councils:

Glover, M. E., Co-ordinator

Williams, Dr. J., President

LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Tuesday, February 24, 1987

The Committee met at 2:05 p.m. in room 228.

The Chairman: Call the Committee to order, being five past two. There is a scattering of members here. I will call the Committee to order. We have two deputations this afternoon. The third, from the Association of Homes for the aged have had to cancel and has not been able to reschedule to come before us.

Our first group this afternoon is the Ontario Coalition for Nursing Home Reform. Would Miss Steffler and associates like to come forward and take your seats directly in front of me. A certain punishment you have to go through by having to look at me for the entire period. You can look at the parliamentary assistant if you want to, that will make things easier on yourself.

The way we operate is to allow you to go through your brief any way you would, and it is a substantial brief so I am not sure how you want to proceed on that, and then we will open up for questions following your brief.

First, besides welcoming you, I should ask you to introduce yourselves so that Hansard will know which is which.

Ms. Steffler: I will start then by introducing myself, Verna Steffler. I am Chairman of the Ontario Coalition for Nursing Home Reform.

Next to me is Judith Wahl, and Judith is our legal counsel for the Coalition.

Ruth Robson, on the end, is a member of our executive committee.

The Coalition for Nursing Home Reform is a coalition of organizations and individual members that comprise a membership of over 400,000 people, and we believe that nursing home care in Ontario is not adequate at present and there must be alternatives to institutional for the people of this province.

Now at this point, believe me, we have gone over this many, many times, your amendments; and the number of times that we met prior to the amendments -- to discuss what we felt should be in it. So many of the things within our paper we have already presented before and we still have strong convictions in regards to them.

I think Judith will go through and highlight the major things that we wanted to point out again.

The Chairman: You haven't done it before this group, though--

Ms. Steffler: No, we haven't.

The Chairman: --so it would be wise to, if you want it on the record before the Committee, it would be wise to touch on matters with the outlines you wish to highlight.

Ms. Wahl: I am going through the Amendment Act section by section. I am going to be omitting some sections. The Coalition has not made up specific response to every single section; some of them are satisfactory to the Coalition, and that's why we haven't commented.

The biggest problems that we see with the amendments are the enforcement of it. Although in general the Coalition would agree with many of the amendments, some of the forms, the way they have been put into the amending act, or the enforceability of its structures that go underneath it haven't been put in there, and we feel that is a major omission.

First of all, the Coalition feels that there should be a standard written admission contract on entrance to a nursing home. A resident should be given a standard contract. The contracts would include the statement of rights in that document; this would make it clear that the resident would have a right of private action against the home, if necessary. It would also give them information as to what are the rights, what are the rules within the home setting.

In terms of the fundamental principles, we are pleased that there has been seen a need to articulate the rights of residents but again, in this section, we would object to the format of it. It has been set up as an interpretive section rather than a substantive section. If you want to make the residents' rights really a matter that residents can use, that they are clear, that they can be enforceable; they have to be taken out of this interpretive format and put into it section by section, and the precedent for this in the Child and Family Services Act - I find it interesting that we have felt that in the past the need to put children's rights and articulate them in a format that is clear, but we haven't done that for the elderly and the handicapped people who live in nursing homes.

As well, the way many of the sections even in the rights, the way they are worded, it is worded in a paternalistic style. Rather than saying the resident has a

right to, they can put in the resident will have the opportunity to have. We are talking about rights. They should be put in a positive format. The residents either have the rights or they don't. Again, it is for clarification. If you can adopt the idea of an opportunity to, even if you put that in the section, it is not going to be enforceable; it just opens the holes for not enforcing them.

We have put into the brief different examples of how some of that wording could be changed; for example, each resident has the right to proper shelter, food, personal and nursing care in a manner consistent with his or her needs.

The subsection (24) is particularly vague and subject to misinterpretation, that is the section that is dealing with the medical records and medical treatment. On page 6 of our brief we have set out an example of how it could be reworded, so you are setting out exactly what the rights are of the resident.

This is also a clarification in terms of staff. If you merely put it in that somebody has the opportunity to object to receiving a particular kind of medical treatment or refusing medical treatment, it is not clear to staff what that means. So that needs to be put in a format that is clearer.

Subsection (25) does give to the resident a right to obtain an independent medical opinion concerning discharge or transfer, but it doesn't give any mechanism of what you can do with it. So the resident goes out and gets a second medical opinion and the nursing home doctor says no, we are agreeing with our opinion, we don't like the second medical opinion and still discharges. There is no mechanism which would let the resident say look, I have got a contrary medical opinion; I want to challenge the potential discharge or the potential transfer. Again this deals with the problems of enforcement, that really hadn't been dealt with in the amendments.

Section (26) does confirm the right of privacy that residents have within the home. But we would submit the right of privacy needs to be expanded, which would include the right to send and receive unopened mail on the day of delivery, the right to privacy during visits from a spouse, the right to share a room where the spouses are both residents. Again, removing the words "have the opportunity" to change it to "to have the right to".

Section (29) gives the right to the resident to be informed of any law or rule or policy affecting the operation of the nursing home, as well as the right to express his or her opinion concerning the operation without fear of reprisals. But again, it doesn't give the right to

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actually see the documents, they are to be informed of these policies. But there is often a big difference between what you are told and what is on paper. So the right to have access to that material, and the right to ask for copies of that material is very important.

There must also be included, if this is to be an exclusive list of the rights of the residents, which we would submit it shouldn't be, it should be a setup where these are a listing of the rights which does not exclude residents' rights otherwise; the rights to sue for negligence, the rights in the criminal process, and also those other rights that may appear under other pieces of legislation or in the common law.

It must be included in the Act the resident has the right to manage his or her own financial affairs. There is some reference to this in the regulations. You have to look at what was in the regulations to make sure that it is also placed in the listing of rights.

Another one that is omitted from the list is the right to consent to the entry to the home and the right to refuse that consent.

Residents must also have the right to be free from medical and physical abuse, and free from chemical and physical restraints. That right was not included in that list.

It must also be clear in the legislation that if there is this listing of rights, and if a resident is not mentally capable of exercising those rights, then the resident's guardian or next of kin would have the authority to exercise those rights.

The biggest problem is the enforcement of these rights. How do you go about making it an effective process? Enforcement really is a three-stage process. Enforcement is identification of a problem, the correction of a problem, and then offering a deterrent so that the problem won't reoccur. With the residents' bills of rights it is important that the enforcement be speedy, that they see something is happening quickly. Many of these people are very elderly, and an infraction of their rights that directly affects the quality of life, they can't wait for four years down the line through a court action to get the relief. They need the relief fast, they need it now.

Different mechanisms could be contemplated to be inserted in the Act. Whether this be a tribunal process where the residents could make complaints to a tribunal that is set up for that purpose, whether the Nursing Home Review Board is expanded to have the authority to deal with breaches of residents' rights, whether it is an arbitrator

system; something has to be put in the Act other than the route to litigation to make sure these rights are going to be enforced properly.

If a standard appeal or review process is not included for all breaches of residents' rights, at a minimum, it must be addressed in the legislation - a review process for involuntary transfers and discharges. Right now the resident doesn't have the power to refuse or question a transfer. Again, the amendments provide the right to get a second medical opinion, but what do they do with it.

A process should be set up whereby if a transfer is contemplated the resident gets a notice. They are given an opportunity then to respond. If they want a hearing, then a hearing is set up so that it can be properly reviewed, they can present their contrary medical evidence to that hearing, and that no transfer would take place pending that hearing.

The transfer is a particularly important issue because of the effects of transfer trauma. This is well documented, particularly in U.S. reports, that when an elderly person is transferred they could suffer -- it could be very detrimental to their health; the importance of putting in the review process, particularly for the transfers.

The Coalition supports the requirement for posting of the residents' rights in the related section for the nursing home, and a provision of copies of these rights to the present residents and also to any residents who are being admitted into the home.

One issue that was not dealt with in the amendments is the issue of licensing. Now it does say that all nursing homes must be licensed. That is clear in the Act, but it doesn't say that the Ministry must enforce that in any way. The Act should be amended to give authority to the Ministry of Health to inspect and strictly enforce the licensing requirement, and breach of a licensing provision should be met with a substantial fine. We would submit that the present fines under the Act are not enough to deter somebody from running a "bootleg" nursing home.

The investigations as to whether a place is a nursing home or not should be done by the Ministry of Health, not the Public Health Department, which has been doing it, I know, at least in Toronto, because the Ministry of Health is the one who is enforcing this Act, they know what a nursing home is better than anyone else. They should be doing those inspections.

In terms the grant of licence and the renewal licenses, Section 44(a) of the Act makes reference to public interest. We would submit that in order to really obtain the actual public interest within a community that there

must be a system of licensing which provides for public hearings if the public wishes to have input. And a precedent for that is under the Planning Act. There is a process whereby notices are put up when someone is going to have a rezoning, the public is given announcements that this is going to occur, and then they have the opportunity to respond. If the public doesn't respond, then the process continues on; but if they do respond then there is an opportunity for a hearing. By having that hearing process, you are going to know what the public interest is.

In terms of the refusals to issue licences, the Coalition supports the inclusion in the Act of the consideration of the past conduct of the applicant, including the conduct of the officers and directors and persons with a controlling interest if it is a corporation. And we are making an assumption here, and it is really a point of information for the Committee, we assume that the consideration of the past conduct would include the consideration of any past record of violations of the legislation in the operation of other nursing homes in a chain, not just that particular home.

Section 4, statement required. There is a provision in the amendments where the director can get a statement from time to time concerning the officers and directors and the ownership of equity shares. We would submit that this should be done on an annual basis. It can be part of the annual financial statements, and this way the information is constantly coming in. The difficulty, when you have it from time to time, either that it is not pursued or you have the problems that have occurred in the present registration of corporations. Many corporations forget to file the Notice of Amendment. If this was on an annual basis it would clear to the operators as well that they would have to report.

In terms of Section 4 on management contracts, the Coalition agrees with the requirement for approval of the director where a licensee intends to enter into a contract which effect is to change the management of the nursing home or the ownership or controlling interest in a licence. We would submit that there is one section that is missing from here. There should also be approval of the administrator by the director. Again, the precedent for this is under the Homes for Retired Persons Act.

The administrator is the key person within the nursing home. It is the person who really is the day-to-day operator of the home. It is important that they meet certain criteria, they have certain education background, that they have the experience to recognize and meet the needs of residents in nursing homes. Again, we have looked to the U.S. for an example that this has been done. In almost every piece of nursing home legislation in the U.S.

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there is a requirement for licensing of the administrator. We are not recommending the licensing, but recommending the approval of the administrator by the Ministry of Health.

Section 10, referring to Section 13 of the Act, a relief in special cases in the agreement for extra services. The understanding of the Coalition that the amendment is sought to give flexibility to the Ministry to permit increases in services and beds for a specific limited period of time for emergency purposes only. If that's the intention, then the section needs to be reworded to put into effect that intention. As it is worded now it is very broad, very open. It is the the Coalition's position that the time period contemplated in this section should be less than 90 days. If there is a need to increase or decrease the number of beds in a home or the services within a home then it is a matter of licensing. It is not an emergency issue; it is not a short-term issue; it is something that will affect the residents on a long term. If temporary increases in beds or services were given to facilities, we also expect that the agreement of the increase will include a requirement for additional staff, it just follows along with that so that there is adequate staffing.

As well, we feel it is very important that the section not open the door for nursing homes to provide community services, such as Meals on Wheels, Respite Care, and other care services. Community services are community services. Institutional services are separate from that. In Ontario we already have the highest degree of institutionalization in North America, we don't need to open the door for more people entering into the institutional setting. We are looking for a commitment from government to the delivery of community services from the community base.

In terms of Section 11, the excessive charges prohibited, the Coalition agrees that the Ministry must regulate excessive charges, particularly in light of the captive situation of the residents. They are in a totally controlled atmosphere, it is very difficult for them to exercise consumer power in respect to services delivered by the nursing home. But there is a need for clarification of what services are ensured or are not ensured, and this information must be given to the residents on entry to the home so they know what they are paying and they can monitor the expenses themselves.

In terms of the recovery of excess payments, the Coalition supports the amendments to this section but it must be stated clearly in the Act that these provisions do not replace the right of a resident to personally make claim for recovery of excess payments, in addition to the power of the Ministry to take the steps to enforce. In most cases it will be the Ministry who would be enforcing to get back the excess payments. But in the event the Ministry doesn't take

the steps, the resident must have that right to continue on with their own private right of action.

The resident must also receive monthly statements. If they are going to be able to effectively deal with their own financial affairs, they need to know what expenses are being charged to their account, and the statement should be going to the residents unless the residents themselves are not mentally competent to receive those documents or have otherwise indicated they should go to other persons.

We would submit that the Act must also include a section specifically prohibiting staff, owners, administrators, the licensee of nursing homes being appointed as power of attorney by residents. I know that it is a matter of policy in some homes, it should be put in the legislation.

Turn to section 15, the reporting of abuse. The Coalition supports the inclusion in the Act of a requirement to report abuse, but again we are missing the enforcement procedures. It says that the abuse should be reported to the director, but what happens then? We submit that the abuse section is so important that there should be a mechanism put right in the legislation detailing out when the reports have to be made, how fast the Ministry is to respond. We submit that they should be responding within 24 hours with a site visit. As well, we are not recommending expansion of the powers of the Inspection Branch to deal with the problems of abuse. If it is not something that falls within the Nursing Homes Act, then the branch should be referring the cases to the appropriate authorities to deal with, be it the police or the public trustee's office, or if there is a public guardian's office created in this province, to that office, or to whatever is the proper source. The abuse reporting section could be enforced if the penalty section is amended to include severe penalties in event of reprisals.

Financial statements. The Coalition also supports the requirement in the amendments for the filing of financial statements. The nursing homes receive public funds and should be accountable for those.

Again, in terms of the enforcement, we are looking at some things that are missing. The Ministry must specify standard reporting formats. It is one thing to say everyone is to file financial statements, but there is many different ways of setting up the statements. If this is going to be an effective way of monitoring how the money is to be spent, all homes have to report in the same manner so that the data can be collected and there is going to be a true investigation as to what reporting means.

As well, if the facility is operated by a management

corporation, the financial statements have to be provided by that management corporation so you don't have the situation where you are falling through the holes: where a management corporation takes over, they don't have to report and the actual licensee is getting around the financial statements.

Now Section 15, dealing with the residents' councils, residents' council advisory committee, and the residents' council advisers. The Coalition objects to the development of this three-tier structure for the residents' council. If it is the intention to strengthen the residents' council and to make them an effective voice within the home, we submit that this structure fails to meet those objectives.

First of all, if you are looking at the residents' councils not being established unless there are at least three persons who are either residents in the nursing home or representative residents request such development, you have to also include a requirement of the home from time to time to inform the residents of their rights to form the residents' council, and also inform all residents on entry into the home of their right to form a residents' council.

The function of the residents' council isn't detailed in the amendments. It is the residents' council that has to have the powers, not advisers and not an advisory committee to them. A residents' council can be effective to investigate and resolve minor conflicts within the home. They could have the power to review records, but they should be burdened with duties that rightfully belong to the Nursing Home Inspection Branch. The primary power to investigate complaints, inspect premises and review nursing home records must continue to lie with the Inspection Branch of the Ministry of Health.

Community participation in the residents' council is very positive and it should be encouraged, but we question whether the residents' council advisory committee is going to provide that true community input. As it is structured, the residents' council advisory committee is appointed by the Ministry and the residents' council doesn't have a veto power over who is appointed.

We would submit that community participation can be obtained if the residents' council structure was expanded to permit outside people participating on the residents' council. As long as the resident has a majority of seats, the resident and these outside community people could be either elected by residents or selected by the residents' councils and asked to sit. I am thinking in terms of a board of directors. You can get outside people coming into the home and playing a role on the council itself without taking the control out of the hands of the residents themselves.

Many of the sections, other than the idea of investigations, that the duties that have been set out to the advisory committee could be within the purview of the residents' council. As long as the Ministry still has the primary role, the residents' council could play a role in dealing with reports to the Minister. They could report their own concerns to the Minister without having a special advisory council doing that for them. The residents' council should also have the right to obtain independent advisers, rather than having an adviser appointed by the Minister. The independent advisers may include lawyers, accountants, dietitians, any type of person that could provide assistance to that council for a particular problem.

We would submit that what should be put in the Act is a funding mechanism for the residents' councils to obtain funds to retain that expertise, rather than setting up a permanent adviser for that council.

Penalties. Penalties in addition to fines must be included in the Act. Right now we really have a black/white situation; either you don't enforce the Act, or you get fines or you get to be licensed. The sanctions that are in the Act are very dramatic; they are not going to lead to effective enforcement of the sections the Act, particularly of the residents' rights. Other penalties could include a freeze on admissions, close supervision of facility paid for by the licensee, prosecution of directors and officers of the corporations, and the cost of reinspection being borne by the licensee. Violations could be graded, so that you have the more serious ones being dealt with in a more serious matter, particularly violations concerning care and breach of residents' rights.

There were two issues that were not dealt with in the amendments: in-service training. We submit that there is a need for requirement for in-service training for staff to be included in the Act. The regulations can deal with the form and content of the in-service training, but there is a need for that ongoing training, when you consider that many of the staff members in the home are health care aides, many are on contract as well. They don't have a lot of experience, they don't have a lot of expertise. The ongoing in-service training is the key for providing for the quality of care for the residents.

And a minimum staff criteria. The amendments do not contain a requirement for a minimum staff criteria. The present regulations include staffing requirements. We submit that the Act must be amended to include a requirement that staffing must be determined based on the need of the residents in the home from time to time. The problem of chronic understaffing in the homes, I think most groups and even staff groups and the homes themselves will talk about chronic understaffing. There is a need in the Act to put

that requirement in so that can be enforced more effectively.

The Chairman: Just to sum it up, you basically like it the way it is?

Ms. Wahl: Except for...

The Chairman: Mr. Cooke?

Mr. Cooke: Thank you, Mr. Chairman.

On your comments about the bill of rights, would it not be important in addition to having a bill of rights, which we don't have here, but also having a statement of principles as well that says how the principles under which the Act are to be interpreted?

I mean, aren't they both important?

Ms. Wahl: You can have an interpretive section - I don't think there is an introductory section - to that in which the whole Act would be interpreted in that fashion. That would be reasonable to include that. But you also need that bill of rights if you are going to make it truly enforceable.

Mr. Cooke: Page 17 of your brief you refer to the alternative penalties, and specifically you refer to a freeze in admissions. I am just wondering, since I have heard this proposal before, in considering the fact that nursing homes are privately owned and therefore they are considered property and so forth, would it not be impossible to have that type of penalty without having the same appeal mechanisms, and so forth, that are in place for the other mechanisms for either taking over a nursing home or imposing financial penalties?

Ms. Wahl: There has to be due process. What we are suggesting is that there has to be a fair process in both directions. If there is going to be a freeze on admissions you do have to do the review system to give the opportunity for the homes to challenge it, and that is any kind of penalty. But we believe it can be structured that it is not going to take litigation to go through. You can do some of that before review boards rather than going through the courts.

Mr. Cooke: My concern is if you freeze admissions, if it is unsafe for any new residents to come into that nursing home and if that is the the opinion of the Ministry and that is why they froze the admissions, is it not also unsafe for the residents that are there?

Ms. Wahl: If that's the reason for the freeze on

admissions, then the Health Facility Special Orders Act should be invoked, and it shouldn't be going just for freeze on admission.

Mr. Cooke: But if the violations in the Act, no matter what they are, are adequate enough, violations are serious enough to freeze admissions, that's my point. Would it not make more sense to look at the step of taking over the nursing home?

Ms. Wahl: I can contemplate the middle ground. Say that you have a whole series of minor infractions, something that wouldn't lead to the Ministry invoking the Health Facility Special Orders Act, it is not as dramatic, you don't have enough evidence to go that far, but there is consistent minor infractions of the Act; you might be able to use the freeze on admissions in that manner.

Mr. Cooke: Where the violations of the Act point to the fact that a resident's health, safety, or welfare are in danger, that's when, I guess, the takeover of a nursing home ultimately occurs. Under the current procedure, as we saw with Country Place, the initial steps occurred in the fall of 1985, and it took all of this time to get to the point where the legislation was actually used.

Would it not be appropriate to look at an amendment to this legislation that says, where a resident's health, safety or welfare is at risk, that the Ministry must... and then spell out time periods where they must take action to take over the nursing home so that we move quickly rather than the process that is currently used now?

Ms. Wahl: That would not be unreasonable. That is one of the difficulties with this Act, both the Act and the amendments is the enforcement, and the speed on the actions. Any process that can developed to increase the speed of enforcement would be of value to the residents.

Mr. Cooke: With regard to the residents' council, certainly the arguments that have been used before this Committee by both the Ministry and by people that are supporting the idea of the residents' council advisory committee and the adviser, is the whole concept of community involvement and, therefore, a better understanding and perhaps improvement, which we certainly support.

If we went the route of having public hearings for licence renewals and issuance of new licenses, would it not be then appropriate that we could eliminate the residents' advisory committee, look at some of the powers that the Ministry are proposing be granted to residents' council advisory committee and give them to residents' councils? We are not talking about powers that say receive and investigate complaints. I am not talking about those kind

of powers, which I believe should lie with the Ministry inspection people, but some of the other powers, and then perhaps just look at having the availability of a residents' council adviser.

I personally can see, perhaps, maybe I am not seeing the negative aspect, but I can see the idea of a residents' council adviser just simply - just as with tenants organizations or with other community groups, where there are advisers and there are people there to assist, not to dictate but to assist in the running of the organization and advising individuals of how that organization can be run and what their rights are, and so forth. But would it be adequate for community involvement if we had the public hearings and then eliminated the residents' council advisory committee?

Ms. Wahl: From the point of view of the Coalition, I don't think it goes far enough, because the way it is structured now, even if just you have permanent advisers, you are taking the power out of the residents' councils to a point that they want. The residents' council, these are people who are competent, they may be frail, but they are competent to make decisions for themselves. And here we have a structure where the Ministry is going to say well, you are going to have this advice, and what kind of an adviser. I come from the perspective of a lawyer. I read this and I say well, that's a lawyer. Give it somebody else who is an accountant, oh well, that's an accountant.

Mr. Cooke: I thought it was a social worker.

Ms. Wahl: There are you are. So who is going to play that role of adviser? That adviser is not independent. If you are going to say that the residents' council is a viable body and that these people have the right to make decisions for themselves and to seek the assistance that they need, you have to give the powers to them to pick who they want. Put in the structures that gives them that ability to do that. Give them some access to some funds to retain somebody so that they can get who they need at that time. If there is a food problem in the home: food is not good, a consistent problem and the residents' council is getting a lot of complaints, who do they need an adviser at that point? They need a dietitian or a nutritionist. If there is a nursing problem, they need a nurse to give them advice at that...

Mr. Cooke: So basically you are suggesting that the advisory committee and the advisers is that currently they should be totally scrubbed. What about dealing with the powers that were granted under this to the advisory committee? Do you think any of those powers would be appropriately transferred to the residents' council?

Ms. Wahl: You can include to residents' council authority to do things such as look at records, to have access to the records. You can even include a shopping list of what their duties are in the sense that they are to meet with the nursing home operators. Those types of duties that are in there. As long as it is clear. I don't think it is as important as to what is put in there as long as it is clear that the primary duties for the inspection and investigation of complaints, that's the duty of the Inspection Branch, that's their authority.

So the thing you don't want to set up in the legislation is a method by which a complaint first has to go to the residents' council, rather than going to the branch. If it is a serious complaint it shouldn't be sitting at the council. The council can play a role in dealing with the minor problems in the home. They should have the authority to look at the records. They need those powers to really effectively act as a council.

Mr. Cooke: Even if that was the role we saw, obviously a residents' council would always have the power or the authority to make recommendations on anything they wanted to make recommendations on.

Ms. Wahl: That's right.

Mr. Cooke: That doesn't have to be spelled out.

Mr. Cordiano: With respect to the role of the adviser, you said well, who should that person be? The question is: Where would that person come from? It would probably be better to have a more effective, from your point of view, to have someone on a contract basis to advise the residents' council, so that he can have -- different time.

Wouldn't it be also valid to say that the adviser, this adviser, who acts for a number of nursing homes, would develop over a certain period of time an expertise, and that person presumably would have some background in nursing homes and geriatrics, at least some expertise in that, to work on an ongoing basis to work with residents' councils and develop an even greater expertise so that we really have someone who can offer expert opinions? I think that is what the role would be.

Ms. Wahl: What are the expert opinions for? If it is a problem with food within the home and the council needs advice about food issues, it doesn't matter whether a dietitian -- the dietitian that is coming there is going to be able to answer the questions. They are going to get a dietitian who is familiar with special diets, that's the type of person that they would call in.

The important thing is the independence. You have one adviser who the Ministry is appointing, is that person really independent? Can the residents' council trust that that person is going to give them advice independent from the Ministry? Are they really going to give them what they need at any point in time?

Mr. Cordiano: I guess you can ask the same question about an inspector who is part of the Ministry, an employee of the Ministry of Health. Can we say that about inspectors as well or anyone else at the Ministry of Health?

Ms. Wahl: That's a different issue, because the inspectors have a particular role and function. They have a particular job to do; they are doing inspections. They are not giving advice to the residents' council.

Mr. Cordiano: Okay.

Mr. Cooke: So your basic concern about this residents' council adviser, I guess is the same concern that existed when they set up the advocates under the Mental Health Division, is the independence and how can we really say that we are empowering residents' councils when the Ministry makes a basic decision as to who the adviser is?

Ms. Steffler: That's right.

Mr. Cooke: I mean, the role of the adviser, I am not sure that I buy the idea that if you need an expert on nutrition that you are necessarily going to need to contract with that person to offer the expertise, but if we had somebody there that could help people access those people that could happen. Perhaps we need to look at something where we provide some kind of a budget and allow people to make the choice themselves.

Ms. Wahl: You are also leading into another issue, which is not within the purview of this legislation. The Coalition supports independent advocates.

Mr. Cooke: Yes, I know. So do we. I just don't know when we are ever going to prove it.

One final question and that is on Section 17 of the bill, which talks about the reporting of harm to a resident. The last sentence of the last part of this section that says: "Unless the other person acts maliciously or without reasonable grounds".

What do you think we should do with that section?

Ms. Wahl: I would submit that that should be removed from the legislation. Actually it wasn't addressed in the brief, but that section, the way it is worded, it would be

difficult to want to report because you would be under this constant fear that it is going to come back up in your face, and I think it really opens the door as well for the nursing homes to take action against staff members who are rightfully reporting what is suspected abuse, but that the abuse is not proven. It may open the door for the staff to be fired or reprimanded, and there are other vehicles for that, you know, there is labour relations groups, there is labour law that can deal with that. But it sets up a system whereby who would want to report. So you are caught between a rock and a hard place, you have to but ... And if you do, you are going to be in trouble.

The Chairman: Thank you, Mr. Cooke.

Mr. Andrewes, can we move into questions by supplementary?

Mr. Andrewes: A supplementary on that one. I think you will agree though that there needs to be something to stop frivolous reporting, whatever that means?

Ms. Wahl: Frivolous reporting can be dealt with in the other vehicles. If somebody is constantly reporting abuse that is never proven, if it is shown that they are doing it maliciously the nursing home could seek the other routes to sanction them. They could fire them and it is a dismissal for just cause. You don't need it in the legislation, in this part of the legislation, to have the effect of dealing with the malicious reporting.

Mr. Andrewes: You don't think you need it as a reminder that reports must have grounds and that the individual has to be held to some minimum accountability for making that report?

Ms. Wahl: But it stills come down to the matter of proof, because if you don't leave the door open for people to report what they suspect to be an abusive situation, then you are closing the door before it is opened. You are not giving them the option of reporting it. You set it up and make it so difficult for them to report that they are afraid to.

Mr. Andrewes: But on the other side of the question,, an individual who makes a report without thinking through the ramifications of that report may, in fact, condemn a licensee without substantiation.

Ms. Wahl: But the licensee would be, as you have indicated, if their reports aren't valid they could take action against that person and go into the labour process if it is proven that it was malicious. They have got t just as much evidence in the other direction.

Mr. Andrewes: You are confident that the balance is there? The balance in terms of obligation on both sides?

Ms. Wahl: I don't think I understand the word "balance".

Mr. Andrewes: Well, The balance that there is sufficient protection for both sides in that reporting system is sufficient protection for the employee and the employer. The way it is posed now.

Ms. Wahl: In the amendments itself?

Mr. Andrewes: Yes.

Ms. Wahl: Removing the words "acts maliciously without reasonable grounds" it goes farther. It is difficult to -- any kind of abuse report in legislation is difficult, and to put it into practice. And it is difficult to word any section adequately to really protect everybody in the senior home.

Mr. Andrewes: I guess what you are saying is don't overly word it; see how it works first?

Ms. Wahl: I think you should put it in. I am not a drafter. I don't think anybody from the Coalition would say that they were drafters of legislation. You interpret as many sections as you can. But I don't think the words "acting maliciously or without reasonable grounds" whether removing that is going to upset the apple cart. I think it is a positive amendment to take it out.

Mr. Andrewes: Can I go to the last page, minimum staff criteria. I would be reminded by the Chairman, of course, that we are dealing with something that is not in the amendments, but it is a question that you've raised and I think it has been raised by others, that there is no clear definition of the responsibility of a nursing home operator to his or her residents.

There is an identification at the beginning of these amendments as to what the residents are entitled to, and there is a suggestion that that become part of a contractual arrangement at the time of entry, for a resident of a nursing home, a contractual arrangement between the resident and the operator.

But then the onus is put, basically, on the resident under these amendments to make sure that that contract is followed. I guess what you are saying is that you are suggesting that requirement of staffing must be determined based on the need of the resident in the home from time to time, so they are aiming to be some type of mechanism where

that assessment is made from time to time. Is that what you are saying?

Ms. Wahl: I believe it is now already in the legislation. Whether it is happening in effect is another question.

Mr. Andrewes: There has been an assessment made from time to time of the resident's requirement, and an adjustment made in the staffing levels to address the cumulative requirements of those residents.

Ms. Wahl: That's correct.

Mr. Andrewes: Are you then prepared to acknowledge that each time one makes that adjustment that the cost might be adjusted up or down without hurting that nursing home?

Ms. Steffler: I think so. Your level of care that is required of an individual as they may require more care and you would require more staff, and I guess you do need more money to pay more staff.

Mr. Andrewes: Can I go to page 8? You talk about giving patients additional rights: the right to access to copies of the law, rules and policies affecting the operation of nursing home, and the right to receive copies of the same.

If I can ask your comments on this, because there were other groups in here who were saying the residents' council members really aren't in a position to make this assessment. Many of them are too frail and that's asking a lot of them to handle that kind of material and to make those kind of judgments. Do you want to give me some help with that, please?

Ms. Wahl: The residents in a nursing home are adult people, many of them are very competent, and it is not a question of whether they can handle processing a lot of material or whatever. In terms of access to information, I think all residents are entitled to receive information if they so wish. I am talking about Section 29. It is giving them that information; giving them the access to it; when changes in the law occur, making that aware that these changes have occurred, so that if they want to rely on the legislation or on the change of policy or if they want to make comment on it, then they know that they have the opportunity to do that.

Some residents will choose not to comment. Some residents will not be either mentally capable or physically capable of doing something about a policy they don't like. But that doesn't mean that there are not a lot of other residents and their families who need the information,

because that's their home, they live in that that place. They suffer the effects of any policies.

Mr. Andrewes: So if we now go back to the whole question of the residents' council and the role of the residents' council, you see them able to handle issues and material and documentation, all sorts of things, the technical information, the financial statements, the legal aspects of the regulations, and so on. Do you see them in a position to handle an Act on those aspects of the operation?

Ms. Wahl: They may need assistance to do that, it depends on the particular council. Some councils are more sophisticated than others; some councils have individuals who are more capable; some councils have retired lawyers, accountants, social workers and professionals on them, others don't. A lot depends on the individual group and what that group wants to deal with.

Mr. Andrewes: So there really needs to be almost a quality criteria for the residents' council if they are going to have those responsibilities.

Ms. Wahl: No, that's not what I am saying. The residents' councils need the ability to have access to documents so that if they need to access the records they have that ability to do so. It depends on the home, it depends on how that residents' council is developed. Some councils are very inactive; some are very active and meet regularly with the licensee or the operator. It depends on the group. But if you don't give them the authority to get access to the information, then they are not going to be able to develop.

Even some of the councils that are not very active, an issue may develop; they need the rights to access so that if there is a problem that they can do something about it. Now they, individually, may not walk into the room of the administrator and take on the administrator. They may retain a lawyer, they may retain a legal clinic to assist them, they may obtain an advocate to assist them.

Mr. Andrewes: I guess my concern is that you are asking us to provide the residents' council with a number of rights and opportunities here, and then, at the same time, you are telling me that in different circumstances the ability of residents' councils to handle that information varies from time to time and place to place?

Ms. Wahl: It is the same thing as a tenant. One tenant knows the Landlord and Tenant Act backwards, the next tenant couldn't cope with reading the legislation or cope with any of the policies. But you don't say oh, well, here we have fifty tenants in the room, they don't understand the Landlord and Tenant Act so we are not going to let them have

this legislation, we are going to keep it locked up in a room somewhere so that they can't possibly access that information.

Mr. Andrewes: So you would supplement that situation? You would supplement it with advisory capacity that they could secure advice, and you would supplement it with - what else?

Ms. Wahl: Advocates.

Mr. Andrewes: There is no mention of advocates here.

Ms. Wahl: That's right.

The Chairman: I would like to move along. We are at around three o'clock already.

Mr. Andrewes: Mr. Chairman, one other question.

It is the approval of the directors of nursing homes, but what if the Ministry do not approve? I think you drew the parallel with the American system where there is certain criteria set out for licenseship, and that a nursing home must hire an administrator that meets those criteria.

Now you have sort of flipped that one over and said well, let's let the Ministry approve. What if I operate a nursing home and I hired an administrator and the Ministry don't approve of that person? The onus then is on me to get rid of them, I assume, or probably some contractual arrangement it would pend approval of the Ministry. But I think there is a clear risk that I do not know what the criteria is that the Ministry will base its judgment on.

Ms. Wahl: This is on the assumption that the Ministry makes clear what the criteria are. The criteria should be set out and be very clear whether it be educational background, health criteria, et cetera, et cetera. That needs to be spelled out, in a sense almost like a job description.

Mr. Andrewes: Then doesn't it become easier to issue a licence?

Ms. Wahl: The reason we didn't look at the licensing procedure is because it gets into a whole other level of tribunals and appeals and whatever, and rather than encumber our legislation with that we are suggesting the approval system.

Mr. Andrewes: Thank you, Mr. Chairman.

The Chairman: Mr. Callahan?

Mr. Callahan: I have looked at your submissions and the immediate thing that jumps out at me is that a good deal of this stick-in-carrot requirement arose out of a sense of the past and the things that went on in the past, and that was really, to a large extent I suppose, dictated by the fact that there were a greater number of potential residents than there were facilities.

Now, it seems to me that the efforts that should be expended should be to try to create more eyes to make certain that, first of all, more eyes to make certain that if any of this conduct continues in the future that it will be rectified by provisions of the Act. And I suppose, secondly, is to make the rules quite clear to those who wish to get into the business that these are the ground rules.

The concerns I have got is that, number one, you make it a bill of rights as opposed to the way it is presently set out in the amendment. You get into an adversarial situation right off the bat. I mean, We have seen this with the Charter of Rights. It is a lawyer's dream.

Ms. Wahl: It is very interesting that the residents already have most of these rights. They already have these rights in law but, unfortunately, many of the residents do not know that, and many of the operators don't know that.

In fact, I heard a radio program just after these amendments came down, somebody who operates a nursing home saying that residents: Oh, look, they will have a right to refuse medication or refuse medical treatment. Well, they have that right now. And you need to put it in a bill form within the Act that is going to be clear. It is a sad comment that many people don't realize the residents have the rights now.

Mr. Callahan: But on the other side of the coin, you have the mechanisms in the Act whereby, in either issuing the original licence or renewal of that licence, that it can be determined whether or not the applicant has contravened the Act or the regulations.

Certainly Section 1(a) says "the fundamental principle to be applied in interpretation of this Act..." and then it goes on to say what it is. I mean, that's the thing that I would be looking at if I were a nursing home operator, you know. I am going to be out of business if I don't comply with the provisions.

But my concern is, if you put it in as rights, which rights indicate individual enforcement, individual application, as opposed to inspectors picking up on those things that are wrong or the Ministry refusing to bring new licence issue, you create a whole host of adversarial positions taking place - in many case justified, some cases

may be not even justified - and you create a discomfiture for those people who are in those facilities.

Ms. Wahl: On the contrary, I think you are going to end up with the opposite, because right now the area of nursing home law, and the rights of residents is slowly expanding. More and more lawyers are getting involved in this area, and are more interested in these issues, and I believe more litigation will occur in the future.

But if you put in the Act a mechanism whereby you could get speedy resolution of problems, that people are clear of what their rights are, it is used as an educative tool to both residents and the staff and the operators. They know what is expected of them, it is clear on the record. There can be a method of getting faster resolution and you reduce the litigiousness of the scenario. You reduce the confrontation because you know that the resident, sure, has a right to privacy. So you operate your home to ensure that privacy is available, be it curtains around the bed or a room that families can meet in privately. You build that into your structure because you know that there is this right. So you remove the litigation out of it.

Mr. Callahan: Don't you have that mechanism right now in the amendment in that it provides for these things to be brought to the attention of the residents' council and thereafter to the advisory council, and these are things that can be put forth either by way of an inspector prosecuting or by way of the renewal of the licence or the issuance of a licence.

Ms. Wahl: If it is an interpretive form, the inspectors will, I submit, will not be able to prosecute on that section.

Mr. Callahan: My main concern is that at the present time there are not sufficient - I was told this morning and I think probably correct - there are not sufficient facilities, be they for profit or not for profit, to look after the present needs of the senior population we have and that's not going to get any better in the year 2001, according to some statistics I have seen. The numbers are going to increase dramatically.

Ms. Wahl: That is why there is a need for a commitment for community-based services, so that people will not end up in the institutional string and the services will be available in other formats that are less expensive to operate.

Mr. Cordiano: Supplementary, Mr. Chairman.

The Chairman: Miss Hart must have one.
Yes, Miss Hart?

Ms. Hart: Very briefly, this is a clarification on the supplementary. In your brief, your Section 10 dealing with Section 13 of the amendments, I am not just sure where the idea came from that Section 13 was intended to address emergency services. That was not the intention of the Ministry in drafting it. It is a mechanism for providing additional funding by contract for services for residents in the home; for example, if there was an Alzheimer's unit in the home more funding would be needed for more staffing, but it is by contract, and I just wanted to clarify that.

Also, the other part of that section where you talk about bringing meals on wheels under that section into the home, we hadn't contemplated that as coming out of the interpretation of that section. Rereading it, it looks like it may and we may be doing some rethinking of that.

The Chairman: Thank you.

Mr. Cordiano?

Mr. Cordiano: Very briefly. I just wanted to point out, looking at the role of the adviser, the proactive role, and if somebody thinks that they will be coming forward to the advisory committee, I am sure it could be handled in a ombudsman-like say by that committee. And I think that is what was foreseen in this section.

Ms. Wahl: If it is the intention of that to be an adversary system, it is not independent from the government; it is not under the control of the resident.

Mr. Cordiano: I didn't say adversary. I didn't say that at all.

Ms. Wahl: But you said ombudsman, and the ombudsman systems are advocacy systems. They are methods of dispute resolution of trying to deal with problems, and if that's the intention of this legislation the Coalition supports an independent advocacy system.

Mr. Cordiano: That is not what I was referring to. I am saying simply that if you have a committee that's in place that is looking at some of the disputes, because there are numerous of them that occur in a day or a month, over a period of time, and some of these may be rather small, and some of them may be rather large. What I am saying is that this committee is in empowered to investigate certain aspects of those complaints and, indeed, to have access to information and to work with the residents' council, and I think that is what was envisaged with respect to that section.

Ms. Wahl: All right. If you have advocates that are

independent they would be doing the same thing. Advocacy is not necessarily an adversarial fuction.

Mr. Cordiano: So what you are saying then is that the residents on this committee making up the majority of this committee would not really have the capability of trying to come to grips with some of the problems that are presented in the nursing home?

Ms. Wahl: No. That is not what I am saying. Many of the residents' councils are more than capable of dealing with the problems. But sometimes they may wish to have assistance either for interpretation of legislation, interpretation of policy, strategizing, assisting with the dispute resolution.

Mr. Cordiano: How is that precluded in the amendment? I don't see how that would preclude having an advocate come forward and serve on behalf of the residents' council?

Ms. Wahl: I would suggest that perhaps that it would a bit redundant to have both the advocate and this three-tier system, particularly if it is contemplated that these advisers and advisory committees are going to be paid for out of public purse, and as well we are going to pay for a public advocacy system.

The Chairman: Thank you, Mr. Cordiano.

I appreciate the time you have taken with us this afternoon. I think it looks like we aren't going to be able to guarantee our amendments being ready for the various caucuses and the government, before the weekend.

So just by consulting with the critics in the last few minutes, it looks like we will probably not meet on either Thursday or Monday, but will reconvene Tuesday morning to hear back from, hopefully, groups around those specific amendments.

Would your group be willing to be one of those that appears again for probably a half an hour, along with the Nursing Home Association and maybe one or two others on Tuesday morning? I have asked the various members, the Parliamentary Assistant and the two critics to get their amendments to the groups as quickly as possible so that you have some chance to respond, but it may be that you don't get them until Monday. From my understanding, the legal draftspeople or a person is probably what the problem is, is going to be overloaded with them.

Mr. Cooke: Would the groups not just be getting them from the clerk once we file them with the clerk?

The Chairman: Whatever is the fastest way of getting

it to the groups I would recommend that they use that approach. So if the clerk is willing to be used in that way... But if you feel that you want to Purolate them or something like that on the weekend, please feel free to do so so that the groups have at least a chance to look at them beforehand.

Thank you very much.

The final deputation today is Ontario Association of Residents' Councils. Would you come forward.

We have a copy of your brief and it is circulated to the members already, and our process is to have you just introduce yourselves so that Hansard knows who you are for posterity. We know who you are. And then take us through your brief any way you would like to and then I will open it up for questions following that.

Ms. Glover: Thank you, Mr. Johnston.

I am Mary Ellen Glover. I am the the coordinator of the Ontario Association of Residents' Councils and, as such, I am the only non-senior involved with the organization.

With me is Dr. Jim Williams, who is the President of our Association. Dr. Williams is a resident in a seniors apartment and he is past president of the Residents' Council in his facility.

We are here today to express our opinions on this proposed legislation. How we, who have experience in the actual operation of residents' councils, feel it will affect these councils. To do this we would like to tell you a little bit about our organization, define the role of the council and tell you about a real council in action. By doing this we can better express our concerns about the residents' council advisory committee, the residents' council adviser, the residents' rights and membership on residents' council as they govern the proposed legislation.

The Ontario Association of Residents' Councils was formed in 1981 by seniors from long-term care facilities to offer one collective place for residents in homes for the aged, nursing homes, and other residential and long-term care facilities.

The subjectives are to encourage the formation of residents' councils in each facility in Ontario; to speak with one voice to the provincial government and all other bodies having to do with senior citizens; to promote legislation for the welfare and improvement of the lifestyle of the aged people in the province; to encourage residents in care facilities to participate in the management of the facility; to share and consolidate ideas arising from

various regions in the province for the good of all seniors in Ontario; to promote a standard of care which will improve the quality of life of all seniors; and to identify key issues facing seniors in care facilities; and finally, to assist or advise individual residents' councils and regional bodies in solving their problems.

The OARC is governed by a Board of Directors consisting of six elected officers and nine regional representatives from across the province. Membership is open to all residents' councils who subscribe to the constitution.

The concerns expressed in this brief are those of residents in long-term care facilities. The bill has been reviewed by the OARC executive committee, and to ensure the views expressed by the executive are truly representative, they were discussed and have been reviewed by a residents' council operating in a local nursing home.

In this brief we want to make you aware of the role of the residents' councils in the home, as well as items of business from actual councils and how they are dealt with. By doing this we hope to better illustrate our concerns about the bill, especially in the areas of residents' rights, membership by the residents' council, residents' council advisory committee, and the residents' council adviser.

Our main concern with the proposed legislation is that it appears to encourage an adversarial attitude in the home. We are concerned that an adversarial relationship will detract from the Minister's goal of making the nursing home, first and foremost, a home to its residents. OARC feels strongly that this goal can best be reached through the development of a spirit of cooperation within the home. All groups within the home, the residents, staff, and administration must be educated to develop such a spirit of cooperation. Cooperation and a sense of family will not develop in an atmosphere where the participants feel threatened or coerced.

While our members were concerned with the tone of the legislation, they are very pleased with some of the goals expressed here, and are encouraged that a beginning has been made in the recognition of the resident as the most important cog in the wheel, the acknowledgment of residents' rights, the acknowledgment that a residents' council can play an important role in the home, and the fact that our frail, elderly resident may need some assistance to reach his goal.

We hope that some of the concerns expressed by our organization and others will be taken into account before this legislation is finalized. There seems to be some

difficulty about what exactly is a residents' council and what exactly a residents' council should and can do. A residents' council is the vehicle through which residents can share in the planning and controlling of their lives. A council can seek changes in living conditions for the residents, prevent services from deteriorating, convey the needs and preferences of the residents to the administration and others, represent the residents to the outside community, educate and inform the residents about facility policies, community resources, rules and regulations governing long-term care, act as a forum for guest speakers, make information on changes which will affect the residents' lives available to them.

A residents' council represents all the residents in the home. It usually has a democratic pre-elected governing body which can consist of an executive committee only, or an executive committee which is part of a larger group representative of the entire resident population. It has a constitution in by-laws which have been democratically adopted. The council is independent but operates in the spirit of cooperation with the Board of Directors, administration, and staff of the home.

As indicated previously, the role of the residents' council is much broader than simply dealing with individual or group problems. The council should be a positive force in the home, bringing changes which will benefit all. In fact, with individual problems, people are often reluctant to bring personal problems to a large group, such as the council. People needing assistance are often concerned about the preservation of their privacy and, therefore, hesitate to bring their problem to a public forum.

When a council is involved in handling individual problems, they are sometimes dealt with by a subcommittee of the council. In other homes these problems are handled by a separate committee made up of residents, staff and family. Some very progressive residences are even looking into the possibility of having a resident ombudsman in the home.

As I mentioned earlier, in researching this brief I spent an afternoon with the executive of a very active residents' council. They were preparing the agenda for the next meeting of the council, and their discussion illustrates perfectly the concerns and actions of an actual council. They dealt with, for instance, the traffic jam at the dining room entrance caused by an increased number of wheelchair-bound residents, a reminder to staff about bringing residents to the dining room in time for meals, an upgraded milk and orange juice, repairs to furniture, hot water problems, the current status of their Korean foster child, that the welcoming committee begin, a new non-smoking policy, occasional fire-door blockage in the new lounge which had proved extremely popular, problems with the wandering resident, problems with the residence' cat,

council newsletter and press releases, having the local MPP as a guest speaker at their annual meeting, and the interaction of the local facility to make them retire.

This council is a perfect illustration of one operating in a home where there is good support for it from both staff and administration. A staff member was present at the meeting at the invitation of the council. She expressed no opinions; however, she did act as the facilitator for the council. For instance, she was able to take the concern about repairs to furniture directly to a meeting of the Health and Safety Committee, which was being held the same day. She also brought to the council several concerns which the administration wanted the council to discuss and decide upon.

This residents' council represents a group of interested, aware people able to make decisions and requests. They operate in a spirit of cooperation with the administration and the staff, and they make use of services provided by the facility to help them implement their decision. This council is not the average, it is the ideal. It is an example of what can be accomplished when all parties in the home are given the education and the tools necessary to work cooperatively.

I would like to talk now about the residents' council advisory committee, its power or proposed power, and our concern. This legislation in providing for a residents' council advisory committee takes a big step towards filling the need which has long been a concern of the OARC. We have consistently held that a group of frail elderly need assistance to be effective. Indeed, we have already shown how effective a council with someone to act as their hands and feet can be.

However, we have concerns that the legislation, as it is written, will eventually emasculate the residents' council rather than enhance its role in the home. Our main concern lies in the fact that the legislation pursues an adversarial relationship between the home and the resident. The role of the residents' council advisory committee does not seem to help the residents' council access services which will improve the quality of life in the home, but to police the activity of the administration. It seems to be that the home never acts in the best interest of the resident. We feel this attitude may be self-fulfilling with the home becoming more defensive and less willing to cooperate.

While the membership outlines to the residents' council advisory committee provides for a majority from the residents' council, the committee is not responsible to the residents' council. This removes power from the residents' council, putting it in the hands of the Ministry. There is

no effort to help the council help themselves, but rather the emphasis is to do on behalf of the council.

There is no provision for input from the residents' council or from the administration of the home and the appointment of members from outside the home. Because of this, it was quite possible that people who have no knowledge of or experience with residents' councils will be appointed, and because of this lack of knowledge will be ineffective. At the very least the appointee should be selected from a list of nominees developed by the residents' council, the administration, and the Ministry.

Finally we question the value of a residents' council advisory committee as it is presently perceived. It appears to have no role of other than that of watchdog. Why not just make provision for advisers from outside to work directly with the residents' council? This will bring several benefits. First, the council will not be stripped of any powers; second, it will have helped to make it more effective; and third, the resident will remain in control. A recent study at Yale University has shown that elderly residents in the nursing home setting who were taught to increase control over their own lives had lower levels of the stress hormone cortisol, better health, and a more positive outlook than others who lacked this sense of control. Surely this is a goal all parties involved would support.

Furthermore, the Faculty of Social Work at the University of Toronto has just released the results of a project carried out in Metro Toronto homes for the aged. It supports our contention that a defensive attitude in the home is detrimental, and that a residents' council composed of the frail elderly needs support and assistance to function effectively. I quote: "People in management positions need to learn skills of facilitating broad participation and decision making."

Residents' councils need a mandate to monitor their institution's policies and services. They need staff resources and support to enable them to contribute to initiate improvements, to collaborate in resolving problems, and confront difficult situations. Residents' councils need to have strategies that help them reach out to other residents to obtain their opinions and provide information. They need to have a system of leadership development so that they can share responsibilities, and can continue when active members become ill. They need to develop assertiveness and problem solving skills in order to carry out the mandate for self-government and institutional monitoring. They need to use staff as a resource for developing and maintaining resident control.

Again, we must emphasize that the OARC is in strong

agreement with the concept of providing support and assistance to residents' councils, but that we have grave concerns that the legislation with the confrontational tone such as this will fail to improve the quality of life of the resident.

Now to the residents' council adviser. Is it an inspector, a facilitator, or a burn-out victim? As with the concept of residents' councils advisory committees, we are in agreement with the idea that a group of frail elderly needs someone more mobile to help them implement their decisions. But we are not convinced that the proposed legislation will do this. To begin with, the residents' council adviser is not responsible to the residents' council, but to the residents' council advisory committee. There is no indication that the adviser is required to undertake any tasks which will help the council become more self-sufficient or more in control. In fact, the legislation appears to limit the role of the adviser to that of an inspector, see section 17F, (2), (3), (4) and (5).

Again, we refer to the University of Toronto study which shows the need for support services.

Secondly, we feel the legislation as written puts the residents' council advisory in the role of adversary or watchdog. He or she would probably be perceived as the Ministry's spy by at least two out of three groups in the home, rather than someone who was there to help. Because of this, we feel the adviser will not only be ineffective, but will be in such an awkward position that he or she will shortly be a victim of burn-out.

In the University of Toronto study, an independent worker was placed in a residential facility, she was there with the approval of the administration and staff. However, even with that official approval, the worker detected subtle or non-acceptance on the part of both administration and staff. She felt this limited her effectiveness. The worker also felt under stress because she had no project colleagues on site with whom she could confer. If this is a situation in a setting where all parties are supposedly in favour of a residents' advocate, the feeling of non-acceptance will certainly be emphasized in a setting where there may be opposition.

Concerning residents' council membership, the OARC is worried about Section 37(d)(3) of this bill, which allows for membership on the residents' council by non-residents. Ideally we would like to see membership restricted to residents. At the very least, there must be a provision in the legislation to ensure that residents have the controlling voice on a residents' council. Our desire to have membership restricted to residents results from

opinions expressed by our members.

In 1985 we undertook a series of conferences and sponsorship of the Ministry of Health to assist facilities in the development of residents' councils. The question of membership came up at all the conferences and, without exception, the opinions expressed favoured resident-only membership on the council. Residents felt that outside members might not have the same concerns the residents do, and the residents' wishes could be overruled.

It was acknowledged that there are residents who cannot speak for themselves and that there was a need for another type of committee which would represent residents' families and others. This type of committee is in existence now in some facilities at the Quality of Life Committee.

Residents' rights, legal or human? Many organizations, including the OARC have bills of residents' right. Ours was developed in 1981 by a committee of residents from long-term care facilities and includes responsibilities along with rights. We feel, since it was developed by residents, that it truly reflects what the resident feels is important. This guide to residents' rights and responsibilities has been used by long-term care facilities across Canada and the United States as a guide for developing a bill of rights suitable to individual institutions. The development of these bills of rights in each home has been done cooperatively and agreement to abide by them on the part of the resident, the staff, and the administration has been voluntary and done in good faith.

We maintain that residents' rights should be differentiated. Some rights are legal rights and can be laid out with a penalty established for ignoring them. Other rights can be described more accurately as human rights, and depend to a great extent on goodwill of one party to another; goodwill cannot be legislated.

We are concerned that the Ministry in developing this set of principles or rights does not allow opportunity for sufficient consultation or discussion. While this is a beginning, we feel that further action should be taken to include a set of responsibilities as well as rights. This will help impress upon the residents the fact that they still maintain at least some degree of control over their lives to differentiate between hard and soft rights, and to provide a mechanism for homes to develop and agree to individual bills of rights suitable to each home.

In summary, we congratulate the Ministry on taking the initiative to formally recognize the residents as the most important part of the process, that residents do indeed have rights, the importance of self-government for the resident, the need for the frail elderly to have assistance in

reaching their goals.

But we also must reiterate our concern about the confrontational tone of the legislation, and the fact that this legislation may result in an adversarial situation in the home. We urge the Ministry to consider taking steps to make the legislation more positive in tone, provide a mechanism whereby the proposals of the legislation are developed cooperatively, ensure the wishes of the residents are paramount and provide assistance to residents' councils so they may work more effectively.

We thank you for this opportunity to present our brief.

The Chairman: Thank you very much, Miss Glover.

I appreciate your attendance; it appears to be very helpful to the committee.

I have one question just out of interest's sake.

Dr. Williams is a member of an apartment group, as I understand it. Why is it that you haven't brought representatives from nursing home councils with you today?

Ms. Glover: We don't have any nursing home representatives on our executive at the moment. Our secretary, our ex-secretary, was a member of a nursing home - who is a member of a nursing home - but she had to resign because of poor health.

Now, I asked other members of our executive to come along, one of them is confined to a wheelchair, so transportation is a problem; another one is in Ottawa, and another one is sick. The other reason is that we have a very, very limited amount of funding at the moment, and to bring members in from out of town is fairly expensive, and we just don't have the cash on hand to do it.

The Chairman: I wish we had known, we would have assisted in terms of bringing people.

Questions from the members?

Mr. Andrewes?

Mr. Andrewes: I guess we will going to the last page of your presentation when you say your organization is considering taking steps to, the first one, ensure the wishes of the residents are paramount.

At this stage, it is now the fourth day of hearing, and I guess I feel a little frustrated sitting here trying to deal with these amendments, and perhaps had not had that

statement made to us. At this juncture --

Ms. Glover: Well, basically that statement is made by the Minister in releasing the legislation.

Mr. Andrewes: I guess I am surprised to hear you cite it as being perhaps one of the inadequacies of the amendment.

Ms. Glover: Well, we feel it is. We feel that the legislation was developed without as much consultation as could have been with the residents. One of the reasons that I did go to a residents' council to discuss this, and it was a residents' council in a nursing home, and as I said, it was not your average, it was an ideal. They are a very active, interested group of people.

One of the things that they are doing is reviewing your party's position papers. Another of the things that they have done is write to Mr. Elston concerning funding for nursing homes; but, for instance, in the legislation it provides for the residents' council advisory committee to have certain inspection powers. This is perhaps not necessarily what the resident is interested in. The resident really doesn't care if they spend \$2.50 or \$2.70 or \$6.30 on meals in a day. What the resident is interested in is the fact they got better orange juice and they got a different kind of milk.

Mr. Andrewes: When they asked for it.

Ms. Glover: When they asked for it. That's what they are interested in.

Mr. Andrewes: Can you distinguish for me the difference between a set of responsibilities and a bill of rights?

Ms. Glover: I believe in the information that we gave you is included a copy of our residents' rights and responsibilities. I don't have a copy with me now. But if you would care to look at that you will find the difference.

Under "responsibilities" we have here the statement, and the preamble is:

"As in all human societies, individuals have not only rights but also obligations and responsibilities to one, fellow residents, and to the management of the home in which one is receiving shelter."

The the first responsibility is to observe the rules and regulations of the home as in effect at the time of admission and is altered from time to time. This could be as simple as pointing out to people that they have to abide

by the smoking and non-smoking regulations; to treat one's fellow residents, roommates, table companions, and staff with courtesy and consideration, and to bear in mind their rights at all times. Many, many seniors in residential facilities don't do that, they think primarily of themselves. To observe all at times the no-smoking regulations for one's own protection and that of other residents and staff; to participate always and promptly to fire and disaster drills.

Do you want me to go on?

Those are responsibilities.

Now, rights, are to have space and opportunity to work on one's hobby; to write or have written to; to receive any mail or otherwise to communicate without any interception or interference by staff or management of the home; to enjoy privacy in counselling and treatment or care for personal needs.

Mr. Andrewes: Would you help me with the statement principles that are in these amendments, and if you could quickly look at them on page 3 and tell me if you see something there that properly belongs in the statement of rights -- what do you call them again?

Ms. Glover: Responsibilities?

Ms. Andrewes: Rights versus responsibilities.

It may not be fair of me to put that to you without having a chance to think about it, but I think it is important because there may be at some point in time some discussion around making that statement of principles into a bill of rights.

Ms. Glover: Well, I think this is one thing that we would like to hear, some more discussion about it before anything is done on it. In developing this legislation, in the meetings that were held of interested groups, of which there were three, there was never at any time discussion of rights.

Mr. Andrewes: Very interesting. We were sure that there was a very thorough consultation of it.

Ms. Glover: Well, I must have missed the meeting.

Mr. Andrewes: Maybe what we will do is we will give you a chance to get back to that listed on page three, that list of principles, and if you have any further thoughts what about what properly belongs in there, what properly belongs under the category of rights, what properly belongs in the category of responsibilities, it will be a great help

to me.

Ms. Glover: I think it would be fair to say that our organization believes what it is in here is the best set of rights and responsibilities in existence, because we developed them.

I cannot, without some thought and some consultation, differentiate between what we think of as legal and are hard and soft rights.

Mr. Andrewes: Okay.

Dr. Williams: May I just add a word on the question of rights and responsibilities. I think that perhaps we are more generally inclined to think of rights - and not only where seniors are concerned and residents or elsewhere, but who are quite neglectful of the other important area of responsibilities - and I think within a residence, particularly, where there is insistence on rights and not on responsibilities, we may quite readily run into problems and difficulties.

I think it is important from the very beginning when a senior is admitted to a residence that he or she knows that they have duties and responsibilities to their fellow residents, to staff and administration; and that makes for on openness and an evenness, I think, in the ongoing relationship between all parties concerned.

What I am saying, in effect, is that I think there should be that balance struck which may not be struck simply by a bill of rights or a statement of rights.

Mr. Andrewes: I guess that's really consistent with your thoughts about the whole bill lacking in terms of supports for residents, and I am appealing to the confrontational side of the issue.

Ms. Glover: I will be the first to admit that as the co-ordinator of the Ontario Association of Residents' Councils I am not invited into nursing homes that are sadly inadequate. But I also feel that I see a lot of homes, nursing homes, homes for the aged, and retirement homes, and in most of them the attitude of the parties -- where the attitude of the parties is cooperative, things work nicely in the home, the residents' council is encouraged, they are effective. Where the attitude is not cooperative, the residents' council is not effective, and it can simply be that nobody says to them well, here, you can have this, or here, we will do this for you. They just don't say anything. So it is not necessarily a big, bad thing; it is sort of a mission rather than, you know, a commission.

Mr. Andrewes: It is fair to say though, in your view,

the residents' council should not be the agent of coercion for those who don't want to cooperate?

Ms. Glover: I am not sure that I understand you.

Mr. Andrewes: The suggestion in this bill is an issue that is not original to me. The Ottawa-Carleton Council on Aging suggested that the purpose of this bill and these amendments was accountability--

Ms. Glover: Yes.

Mr. Andrewes: --and they were somewhat surprised that the bill was not more positive, and expressed some of the same concerns that you did, that it was confrontational, it was adversarial. And I sense from what you are saying is that the adversarial aspect of this bill seems to fall on the residents' council, and the residents' council advisory committee, and the residents' council adviser to be the vehicle by which those uncooperative nursing homes, that you say you are not invited into, to fall into line.

Ms. Glover: It would certainly seem that the residents' council advisory committee and the residents' council adviser are put in those rules. If you take a good close look at it, it seems that the residents' council is removed from the whole situation.

Mr. Andrewes: Thank you.

The Acting Chairman(Mr. Allen): Mr. Cooke, is yours a supplementary or a new line of questioning?

Mr. Cooke: New line of questioning.

The Acting Chairman: Proceed with your supplementary then, Mr. Callahan.

Mr. Callahan: Just following up on that then, I gather that your belief is that more is created through harmony than through confrontation and adversarial approach?

Ms. Glover: Exactly.

Mr. Callahan: That was what I was trying to get across on the other Committee, and I suppose the concern for that, too, is that if the rules are clear and if the penalties are there for all and sundry to see, and they take the chance of breaching them, they could be out of business. But if you make them so structured you made wind up with even a tighter squeeze in terms of facilities than we have right now, and create even a more captive market where they can do what they darn well please.

It is nice to hear the other side of it is a voice

that... Rights, unfortunately today, seem to be the rule as opposed to the equal or the balancing of the rights and responsibilities, and simply do nothing more than provide a great deal of work for members of my former profession. And I would imagine if it can't be ironed out in a democratic way by the council, I gather that really it is - although it may be enforced through legislation - it is really sort of a stalemate or a truce as opposed to a peace.

Thank you.

The Acting Chairman: Good speech, as my mother would say.

Mr. Cooke?

Mr. Cooke: Thank you, Mr. Chairman.

Certainly one of the difficulties that we are all trying to deal with is the balance between what responsibilities we give to the residents' council and what responsibilities, our primary responsibilities in the Ministry in terms of enforcement.

Do you have a residents' council at Country Place Nursing Home?

Ms. Glover: I don't know if there is a residents' council at Country Place Nursing Home. In April of last year Country Place Nursing Home residents' council applied to our organization for membership. They were sent all the appropriate information including the bill, and we never heard anything more.

Mr. Cooke: Do you find it strange that in this particular nursing home where there has been serious problems ongoing for several years that there wasn't once a complaint from the residents' council?

Ms. Glover: No. I won't say that I find it strange. In working with the Ontario Association of Residents' Councils the complaints that come into our office are not the same kind of complaints that come to other organizations, such as Concerned Friends. We are called upon to take more of a role of a conciliator or a suggester. I get to go to maybe two or three residents' council meetings a month, and the kinds of things that are brought up at the meeting are things like we discussed here.

Now this council had all the ability and all the tools necessary to solve their problems, some councils don't. What they come to our organization for is for support, suggestions and, perhaps, going out and actually finding the person to do it.

Now, in talking about residents' council advisers, I am an ex officio member of several residents' councils around Toronto, in mostly homes for the aged; but I am just there as an adviser, as a support person.

Mr. Cooke: How many of the residents' councils belong to the association?

Ms. Glover: We have 165 members currently. We have doubled our membership since 1985.

Mr. Cooke: If the bill has a bill of rights, and you are suggesting it should be balanced off by responsibilities, how would you ever enforce responsibilities?

Ms. Glover: I don't know if you can enforce responsibilities any more than you can enforce rights.

Mr. Cooke: You can enforce rights, because if they violate somebody's rights then they are in violation of the law. I mean, the only point I am making is that normally a bill doesn't have a bill of rights for residents countered by a bill of responsibilities for residents, because one puts the onus of respecting those rights on the owner of the nursing home; the other one, there would be absolutely no way of enforcing it. Their mechanisms, obviously, for one to respect one another in a nursing home and that kind of atmosphere has to be developed.

I am not quite sure that your point of trying to put responsibilities into a bill of residents of a nursing home is valid. I don't know how you would do it. I mean, if a resident of a nursing home didn't respect one of the responsibilities that you suggest in your guide, would that mean that they are subject to prosecution by the Ministry of Health? I don't think you are suggesting that. That would be highly inappropriate.

Ms. Glover: We are looking at the bill of rights and responsibilities as something which is not necessarily legislative. This has always been the attitude of the association. That bill of rights and responsibilities, as I said, was developed by seniors in residence and it is in place in many, many homes, but it is in place through cooperation, and it works because of cooperation.

Mr. Cooke: You are not suggesting that we shouldn't have a bill of rights in the legislation?

Ms. Glover: I am not suggesting that we shouldn't have a bill of rights in the legislation, but I think that it has to be -- further consideration has to be given to it, to what goes into it.

Mr. Cooke: I agree that we have to give consideration to what is in it very carefully. See, the problem is that your experience with some of the residents' councils is very positive, and I agree that your experience has been that. The difficulty is the laws are passed, regulatory laws are passed, not to regulate the good guys, but to regulate the bad guys.

Ms. Glover: I don't think there is any doubt of that, Mr. Cooke.

Mr. Cooke: I am not sure that by the approach that you are suggesting that you recognize how difficult it is for the Country Places that exist in this province, and I can give you many other examples of nursing homes where the situation is just totally inappropriate.

Ms. Glover: I think one of the things that we are concerned with here is the fact that the bill seems to treat everybody as being a Country Place.

Mr. Cooke: How else do you do it?

Ms. Glover: I think you can do it by providing in the bill for the development of some of the things that they talk about in a cooperative manner; for instance, if you are going to have a residents' council advisory committee, don't have the Ministry appoint it solely, have the nominees elected, as I said, from a list developed in cooperation.

Mr. Cooke: I understand what you are saying, but in terms of the other regulations they are there obviously to say to the people that need to be told that here is what the objective is and here is what you have to achieve. And yet you are right, that when you have regulatory legislation it quite often makes -- it doesn't make any distinguishing factor into who is good and who is bad. But how would you do that in legislation?

Ms. Glover: Well, we didn't deal with that here. We dealt with the things that are of interest to our organization.

Mr. Cooke: Thank you, Mr. Chairman.

The Acting Chairman: Mr. Cordiano?

Mr. Cordiano: Thank you, Mr. Chairman.

I am very curious about what you see as a confrontational bill in the amendments that are being proposed.

In fact, the adversarial relationship that would be lost as a result of depletion of the committee and advisory

committee and the adviser, the role of the adviser, because there are those that would argue that, indeed, what we should have is perhaps more of an advocacy based function - and that's not to say that we are not going to allow for that to take place - but certainly if you have advocacy as the main instrument for bringing problems forward and trying to resolve them, obviously you are going to have a far greater competition or climate than you would if you are working within the home, and with the people that live in the home who have some measure of say in their own destinies.

Ms. Glover: But there are other people in the homes than the residents. There are also staff, and there is also the person who owns or operates the home.

Mr. Cordiano: So what you are saying is there should be some role for the operators of the home and the staff to play in this...

Ms. Glover: If you are doing to develop such a committee it should be developed in cooperation with more than just one group in the home.

Mr. Cordiano: I think what the intention here is to really give to the residents of the home.

Ms. Glover: But you are not giving support to the residents, you are giving support to the residents' council advisory committee.

Mr. Cordiano: I see that the Ministry officials have somehow departed.

Section 17(e), subsection (1), the way the amendment is worded, "there shall be established with each residents' council or residents' council advisory committee to be composed of..."

So, you are establishing this residents' council advisory committee for the residents' council. Now, just what the reporting mechanism and the relationship of the the residents' advisory committee to the residents' council will be, I think that we will have to have further elaboration on that from the Ministry, I suppose, on how that might be worked out.

Ms. Glover: The residents' council advisory committee doesn't appear to do anything but act as a watchdog. They don't advise the residents' council; they don't do anything to assist the residents' council in carrying out the things that the residents' council want done.

Mr. Cordiano: Let's look at subsection (2). It says: "It is the function of the committee and it has the

power to (a) advise residents respecting their rights and obligations under this Act; and (b) advise residents respecting the rights and obligations of the licensee under this Act."

To me that would seem to indicate an educative role for the committee as well as an investigative one.

And then it goes on to describe the number of things that the committee might do in terms looking into other aspects in the operation of the nursing home. But there is a clear role for the committee to play as a educator and adviser, as written in subsection 2(a) and (b).

Ms. Glover: As an adviser concerning their rights and obligations under the Act, not as an adviser concerning anything else; as an adviser concerning the rights and obligations of the licensee under the Act, not as an adviser or an assistant or a helper to do anything else. I will go back to the example of calling in a dietitian which was used by the previous group.

Mr. Cordiano: You are referring that to the role of the adviser, not the committee. And I think one would have to look more carefully at the role of the adviser as set out in the Act. I don't think that it is necessarily limited to the things that are stated in this subsection.

In fact, the adviser would be just that. An adviser, in any capacity, that the committee wished that adviser to take. The role of the adviser I think would come under the consent of the committee and, therefore, that adviser would be reporting to the committee and not the other way around.

Ms. Glover: That residents' council adviser doesn't report to the residents' council, it doesn't advise the residents' council. It reports to the residents' council advisory committee.

Mr. Cordiano: I am not arguing that. What I am saying is that the role of the adviser would be to report back to the advisory committee which, for the most part, would be made up of residents --

Ms. Glover: The role of the adviser is not to help the council carry out of any of their wishes.

Mr. Cordiano: What I am trying to establish is that the advisory committee then reports back to the residents' council, and that is what I am not too clear about. I can see some of the points that you are raising, but I am just trying to point out where all of this fits in, in the three levels, and what each role at each level is.

Ms. Glover: I think our that concern is that in all

this, in all the three levels or fourteen levels or however many levels you are going to end up with here, the voice of the residents is the one that is getting lost.

Mr. Cordiano: Okay. But we have also heard, with the greatest of respect, that some of the residents need support. So you are not suggesting that we don't have people from the outside coming in to support --

Ms. Glover: But they don't necessarily need someone who is checking up. They need the support of someone who will help them carry out their wishes.

Mr. Cordiano: Then again, would it be workable to not have -- Let's suppose we don't have this committee that we envisage in the advisory committee. Let's suppose we don't have that. Let's suppose then that all you have is the Inspection Branch of the Ministry carrying out what it is going to do to enforce the Act, and then you have the residents' councils that we have in place now. Then what you are saying is that we should have a residents' council and add to that members from the community and an adviser, et cetera?

Ms. Glover: Mm-hmm. (Nods head in the affirmative)

Mr. Cordiano: Some of the concern that I have is that the members of the residents' council were very weak, unable to control their own destiny and, therefore, needed support, encouragement, a strengthening of what they might be able to do. Do you have a concern with that or -- residents' councils obviously represent residents' councils across the province, and is it your concern that they need to be strengthened in the fashion that we've seen, or do you think that they can go on carrying out their duties and responsibilities such as they are set up in this point in time, with some support?

Mr. Williams: May I try to answer that question? I think that once we are very grateful for all the council and advice and help and support we are getting from so many groups, we may lose sight of the fact that we have seniors who are very independent, who are able, who have a sense of dignity and individuality, and that these are scattered all across the province within those homes, nursing homes, et cetera, people with wide backgrounds of skill and knowledge.

And I have a feeling, I don't know why I sense this, but I have a feeling that maybe there is an attempt on the part of everybody to sort of do everything for seniors. When, as a matter of fact, we just don't recognize the fact that they are people and that they have abilities, not right across the board, 100 per cent necessarily, because there is frailty and there is weakness, mentally and otherwise. We have to be realistic about that.

The point I want to make is this: That seniors are people and if they are given a chance they can do more for themselves than what they may do otherwise when they have all this wonderful assistance, which we need in some instances, too. I think that that needs to be said and that note needs to be sounded from time to time.

Mr. Cordiano: Before I relinquish to my colleague who has a supplementary, I just want to point out one other thing. You have a problem, as I see it, with the tiers. You have a residents' council, then you have an advisory committee to the residents' council. But you do have the majority of people on this residents' council advisory committee that are from the residents' council, that are members of that residents' council. So you don't see it as necessary for that residents' council committee to exist at all.

Ms. Glover: Why not just have a residents' council that has access to outside advisers. As I said, I sit as an ex officio member on several residents' councils. I am an adviser. I am a member of the community who happens to have a little bit of knowledge about how residents' councils work, and who goes around to other councils who say oh, well, you know, they do it this way there and it works and this kind of thing.

I think the councils need someone to help them help themselves. They need someone to act as their hands and feet. They need someone to help them implement their decisions. As I said when I started, I am the only non-senior affiliated with the Ontario Association of Residents' Councils. I am their employee, and as their employee I do what I am told, whether I agree with it or not, as long as it is legal and moral.

This is the kind of thing we are trying to get across, that residents' councils can function effectively if they have someone to help them implement their decisions. It might be as simple as having someone to make sure that the minutes of their meetings are typed.

Mr. Cordiano: So you don't believe in formalizing the role of community members on the community advisory committee, because that's exactly what he have done in section 17(e).

Ms. Glover: It could be formalized on the residents' council.

Mr. Cordiano: All right. Fine.

Mr. Callahan: Just if I might, Mr. Chairman, by way of supplementary.

We have heard, and Mr. Cordiano has indicated some groups where they have said that the seniors in some nursing homes that get on the residents' council may not be capable of or may be capable of very little. I guess we heard the most outrageous one this morning where the gentleman who chaired the committee was brought documents to sign and he said, "I am not going to sign those because I don't understand them."

Would you accept this as a sort of a mid way mark that you have some form of a committee, such as the advisory committee or as the adviser, to be triggered into action if a group of seniors in a nursing home of whatever area was not able to either set up a residents' council or effectively run it, that you would have them almost as a trustee type situation? So that even though you had success in most nursing homes, you've indicated that there are some that don't have them, either because of lack of knowledge or perhaps because the owner of the nursing home doesn't think it is a good idea, or the third alternative is, that maybe there are not any people there in that small nursing home who were capable of carrying out the functions of the residents' council.

Ms. Glover: There is another alternative, which is little interest, unfortunately.

Mr. Callahan: Is what?

Ms. Glover: No interest on the part of the resident.

Mr. Callahan: Well ... But our basic concern is to see that there is a mechanism to educate them about their rights, to give them some say in the rights, and to make it quite clear to the people who are running it that this in fact is run on the basic principle that it is their home.

I think, if anything, that's the most basic guiding principle that this Act is trying to address is the fact that it is their home. They should be treated with dignity, and so on.

Ms. Glover: We feel that by providing legislation with confrontational tones, such as seems to appear here, you are taking away from the fact. You are not going to do anything to develop a home like that.

Mr. Callahan: I appreciate that. But I am saying if we took out the advisory council and the adviser, and simply said that that would only kick into play if the nursing home residents were not able to either form a residents' council, because of whatever reason, they were incapable or they were being denied it by the nursing home or, in the alternative, that -- I guess those would be the two alternatives, that

there would be some mechanism there to kick in to protect them in that area.

Would you see that as that as a half way measure that might give them the opportunity, as you have said. I think there is a lot of fact in what you say about seniors wanting to do things themselves. If you don't, they just sit there and become worse because they have no responsibility.

Dr. Williams: I think that we have to be realistic and recognize frailty in many instances in our nursing homes. We have to. And if residents' councils are going to work and if they are going to do the job, as it were, adequately, then if in instances this frailty is a problem and if the seniors themselves are unable really to function adequately and effectively, then some such provision, if it were available, would be, I think, most welcome because we have to be realistic.

We can't say right across the board that everything is going to work in every nursing home, because we have an adequate or an effective residents' council, because it doesn't work out 100 per cent like that. But if we had a mechanism or a vehicle that somehow would kick in, to use your expression, to assist, to get the ball rolling, as it were, and to involve the seniors in one way or another in shaping their own destiny and running their affairs and having a richer life, and with greater participation in sharing in it, then I think that something like that, not as structured or as formal as perhaps we have suggested in the suggested amendment here.

Mr. Callahan: Thank you.

The Acting Chairman: Mr. Cooke?

Mr. Cooke: From what you are saying, or from what I am hearing anyway, you are not unhappy with the way things are now in terms of the mandate that residents' councils have now, but what you are saying is the need that residents' councils could carry out that mandate more effective if they had a little help.

Ms. Glover: Exactly.

Mr. Cooke: So instead of having the residents' council advisory committee and the residents' council adviser, and instead of some idea that if the residents decided they didn't want to have the residents' council the government would decide for them that they were going to have it.

And instead of all that, that maybe the appropriate thing for the Ministry to do is to take the current mandate or the current provisions that are in the regulations, put them in the Act which says if they don't set up a residents'

council - the residents don't want one - they have to have this meeting on an annual basis to check it out again to see if they want to have one.

Put that stuff in the Act, and the Ministry and the government should look at some way of flowing some money, maybe through your association, of where you could have some extra staff to go out and help the residents' councils.

Ms. Glover: We would certainly be in favour of anything like that. It would be extra money.

Mr. Cooke: The problem with the residents' council adviser is that the people are going to be direct employees of the Ministry, and anybody in a residents' council or any resident in a nursing home immediately is going to identify that person as being a Ministry of Health person, and no one is going to talk in confidence with that residents' council adviser.

Ms. Glover: Whether they are direct employees of the Ministry of Health or it is done through another organization, that person, that residents' council adviser is going to be sitting in that home and they are going to be disliked by at least two out of three parties in that home, if not three out of three parties in that home.

When I spoke to the nursing home residents' council about this, I said, "What about a residents' council adviser?". This particular home didn't think that they would need one. So if they put one in we just won't pay any attention to him, her, it. Simple as that.

Mr. Cooke: I don't know how, Mr. Chairman, when we have had virtually every advocacy group that has come before us so far say they don't like the suggestion that is in the law, when we have the Residents' Council Association itself say they don't like the suggestion, I don't know how the heck we can go with the suggestion, and I hope that we will look at some...

Mr. Cordiano: Mr. Chairman.

The Acting Chairman: Mr. Cordiano?

You have finished, Mr. Cooke, I gather?

Mr. Cooke: Yes.

The Acting Chairman: Okay.

Mr. Cordiano.

Mr. Cordiano: I just wanted to ask the Ministry if in fact the advisory committee -- what's the relationship to

the residents' council? What reporting relationship do they have and how do you foresee that working and in what capacity?

Mr. Cooke: It is not going to work very well when the residents' councils don't want a relationship.

Ms. Hart: It was not intended that the advisory committee would act on its own without the council. It is merely a creation of the council.

Mr. Cordiano: Will the advisory committee be reporting to the residents' council?

Ms. Hart: Yes.

Dr. Williams: I think that that's not the case.

Mr. Cooke: The adviser doesn't report to the council; the adviser reports to the advisory committee, who reports to the council, who reports heaven knows where.

Ms. Hart: I thought the question was: Does does the advisory committee report to the council, does it not? And it does.

Mr. Cordiano: So what you are saying then is the role of the adviser would be totally and completely unacceptable and would render that person useless?

Ms. Glover: I wouldn't say that the role would be unacceptable, but the person certainly not going to be effective, and the role is limited.

Mr. Cordiano: The role of the advisory committee, certainly you have to make a case for the fact that you have some very serious problems in a number of homes, and we have to open up those homes to the community, members of the community that will come in and take an active role and participate in the goings on in these homes. I don't think you can make --

Mr. Cooke: I have a great suggestion for you, wait until you see our amendments.

Mr. Cordiano: Sorry?

Mr. Cooke: I say wait until you see our amendments, we have a perfect suggestion for you.

Mr. Cordiano: I am sure you do; I am sure you do.

What I am suggesting is that there is indeed a roll to be played by members of the community in nursing homes, and that's what we have attempted to do in this section, is to

provide for those people to have an active role.

Ms. Glover: We certainly would agree that there is a role to be played by the members of the community in nursing homes, in homes for the aged, in all long-care facilities; but I don't think that perhaps the role as established here would be as effective as it could otherwise be.

Mr. Cordiano: Thank you.

Ms. Hart: You did indicate that there was a role for an adviser in terms of facilitating and implementing decisions, and yet you also said that anybody who came in was going to be distrusted. Can you help me on that?

Ms. Glover: The way it is established here that person is going to be mistrusted. The minister with the consent of a committee will appoint a residents' council adviser to assist the committee in carrying out its responsibilities. Now, if you are going to outline in the regulations who is going to be on this committee that helps the minister appoint, well then then maybe that will make it be effective.

Mr. Cordiano: The committee referred to as active was the advisory committee.

Ms. Glover: No.

The Chairman: Mr. Cordiano, perhaps you would wait a moment.

Ms. Hart: What I am seeking some help from you on is how would you structure it so this person is not going to be distrusted?

Ms. Glover: I would like to see the person put in place cooperatively with input from the residents, --

Mr. Callahan: From the seniors, too.

Ms. Glover: --from the administration of the home, perhaps from the staff and perhaps from an outside party.

What I am saying is you are going to have go to get consent from -- you are going to have to get not grudging consent, you are going to have to get consent from the staff and the administration in the home that this person will fulfil, in effect, the function. That person is going to have to have support from staff and administration in the home or they are going to go crazy in a very short period of time.

Ms. Hart: Just so I understand you then, the adviser might in that role be effective as long as the minister got

the consent of knowing the residents' council, but also the staff and the administration. Have I got that right?

Ms. Glover: Yes.

Ms. Hart: Thank you.

The Acting Chairman: Mr. Cordiano, does that satisfy your concerns as well?

Mr. Cordiano: I don't know that that would be something that you can accomplish, given the--

Ms. Glover: We can give it a shove.

Mr. Cordiano: --large number of the three different parties trying to come to an agreement as to who should be adviser. I think it is going to be a little --

Ms. Glover: As I pointed out, if it isn't done with cooperation... It really didn't work; in one instance it did, in the other instance it didn't.

The Acting Chairman: We can deal with that matter when we come to the amendment and debate among ourselves as to what, among the various options that have been layed before us, could provide the best system in that respect.

Are there any further questions?

I am going to ask if you if you have further comments as well, but are there any further questions from the Committee?

Would either of you like to make some final comments for us at the end of our discussion.

Dr. Williams: If I may, Mr. Chairman.

I would just like to say that I think that what we have been saying today perhaps would sort of underscore the point that we are interested in creating harmony and right relationships between all parties involved in a nursing home. And where there is sort of a confrontational atmosphere in existence and the negative approach, you are almost beaten before you start.

It is the atmosphere or the environment that is perhaps the important factor here, and if you have right relations existing between, let's say, administration/staff, you have sort of an educational approach to this and doing what we can to sort of have a right relationship, then I think you have the atmosphere conducive to improvements for the life of seniors and for the health and the happiness of those who care for them.

The Acting Chairman: I would certainly hope so. Do you have any last remarks, Ms. Glover?

Ms. Glover: No, I don't think so.

The Acting Chairman: Thank you both for coming from the entire Association and giving us your advice. We appreciate that very much.

Ms. Glover: Thank you for having us.

The Acting Chairman: Members of the Committee, I don't believe there are any matters we have to discuss at this point either. So I will just simply say that we are -- Yes, sir?

Mr. Andrewes: Are we sitting tomorrow?

Mr. Callahan: As I understand we are not sitting Thursday or the following Monday. So the next time we are sitting is tomorrow and then Tuesday at 10 o'clock.

The Chairman: Right.

This committee stands adjourned until 10 o'clock tomorrow morning.

The Committee recessed at 4:13 p.m.

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